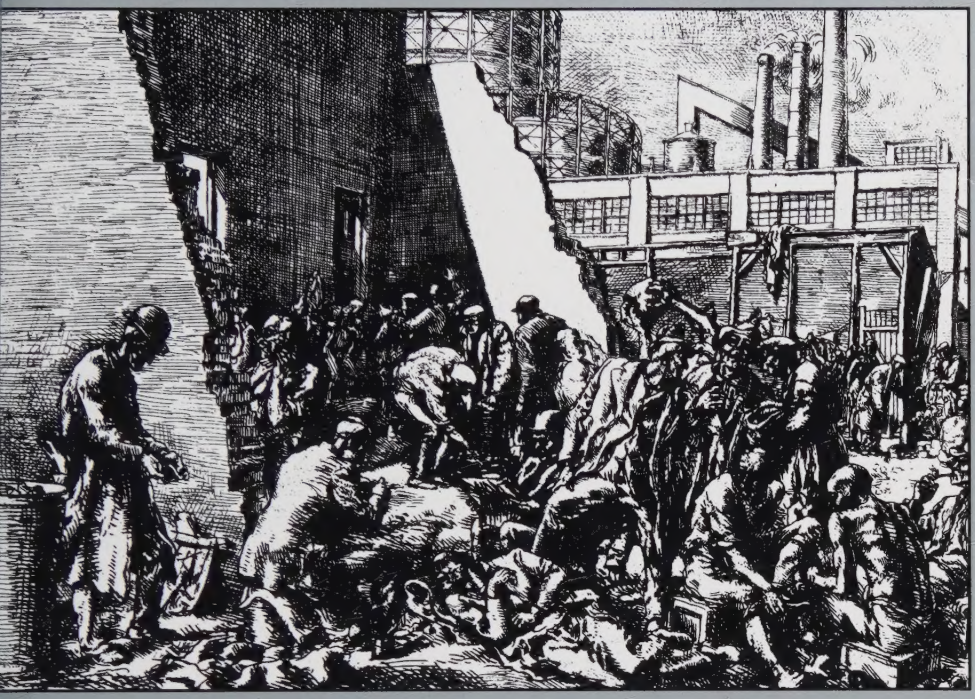

SUBSTANCE USE & MISUSE

Special Issue on Substance Use Among Homeless, Immigrant, and Refugee Populations: An International Perspective

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June 1997

Aims and Scope. *Substance Use & Misuse* is an interdisciplinary international forum for the dissemination of facts, theories, points of view and the highlighting of critical unresolved issues in the related areas of substance use, misuse [licit and illicit drugs, alcohol, nicotine and caffeine], "abuse" and dependency; eating disorders and gambling.

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SPECIAL ISSUE ON SUBSTANCE USE AMONG HOMELESS, IMMIGRANT, AND REFUGEE POPULATIONS: AN INTERNATIONAL PERSPECTIVE

UNIVERSITY OF HAWAII
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Introduction to the Special Issue

Timothy P. Johnson

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BACKGROUND

As we approach a new century, it is becoming increasingly evident that not all citizens of our planet are reaping the benefits of the technical, medical, and scientific advancements that have so characterized recent history. Tragically, along with the many impressive accomplishments of our era, we have also witnessed dramatic social, economic, and political upheavals that have produced countless casualties. Among these have been persons who become *displaced* as a consequence of one or more of these broad structural forces, or of one of the numerous ethnic-religious-sectoral-historical conflicts that have reignited since the end of the Cold War. Displaced persons may include immigrants, refugees, people who have been relocated, often forcibly, within their own country, homeless persons, some institutionalized populations, and other persons who have been separated, either permanently or temporarily, from a familiar social context and who are required to confront and adjust to a new one. A basic, albeit incomplete, typology of displaced persons is provided in Table 1. In reviewing this information, it is important to recognize that various types of displacement are not mutually exclusive and that there may in some cases be considerable overlap among these definitions (see for example Daly, 1996).

Precise estimates of these various groups are elusive. The United States alone is believed to have admitted approximately 6 million immigrants between 1990 and 1994 and 3.5–4 million undocumented immigrants were additionally estimated to be in the United States in 1994 (US Bureau of the Census, 1995). This latter figure is thought to increase by as many as 300,000 persons per year (Warren, 1994). Worldwide, it is estimated that there are as many as 110 million persons who may have immigrated across international boundaries for

Table 1.

Basic Typology of Displaced Persons

Type of displacement	Definition	Process	Duration	Examples
Refugee	Persons who migrate across international boundaries to escape political, ethnic, or economic persecution	Involuntary	Usually permanent or long term	Rwandans crossing into Burundi, Tanzania, Uganda, and Zaire as a consequence of civil war
Internally displaced	Persons who migrate within their own countries to escape political, ethnic, or economic persecution or natural disasters	Involuntary	Variable	Croats, Muslims, and Serbs forced out of native villages and regions in Bosnia-Herzogovina
Oustee	Persons who are forcibly resettled within their country in order to make way for public works projects	Involuntary	Usually permanent	China, Indonesia, and other developing countries
Homelessness	Persons without access to permanent physical shelter as a consequence of economic and social marginalization	Mostly involuntary	Cyclical, often temporary	Metropolitan areas in United States, Western Europe, and other developed countries
Immigrant, documented	Persons receiving government permission to move across international boundaries, most often in search of economic, social, or religious opportunities	Voluntary	Often permanent or long term	Turkish "guest workers" in Germany
Immigrant, undocumented	Persons who move across international boundaries without government permission, most often in search of economic, social, or religious opportunities	Mostly voluntary	Often permanent or long term	Chinese and Mexican nationals entering the United States without visas
Internal migrant	Persons who migrate within their own countries, usually from rural to urban areas, most often in search of economic opportunities	Mostly voluntary	Usually permanent or long term	Nigeria, Ethiopia, China, and other developing countries
Institutionally displaced	Persons condemned to medical, mental, or criminal institutions, often for political purposes	Involuntary	Variable	Psychiatric hospitals for political prisoners in old USSR

economic reasons, including as many as 10 million who are undocumented migrants (Kane, 1995). While there is general agreement that the numbers of refugees has increased dramatically in recent years, these estimates are also difficult to document. Jenkins and Schmeidl (1995) analyzed data from the United Nations suggesting that the number of "official" refugees has increased nine fold between 1960 and 1990. Worldwide, the estimated number of refugees, including "unofficial" refugees trapped in refugee-like situations, was 18 million as of December 1995 (US Committee for Refugees, 1996). Between 1990 and 1994, over 600,000 refugees and other persons seeking asylum were admitted to the United States (US Bureau of the Census, 1995). Of course, refugee counts do not include persons who are internally displaced within their own countries, even though most are displaced for the same reasons that those crossing international boundaries become refugees (Durieux, 1996). Indeed, the numbers of persons who are internally displaced within underdeveloped nations may actually outnumber the world's refugee population. In 1995 the number was estimated at approximately 21 million (US Committee for Refugees, 1996). Within industrialized countries, reliable estimates of the numbers of homeless persons are even more difficult to obtain. In the United States, attempting to estimate this figure is itself controversial (Rossi, 1987) and estimates vary considerably. One recent study suggests that as many as 5.7 million persons in the United States may have been literally homeless at some time between 1985 and 1990 (Link et al., 1994). These recent estimates of selected displaced populations are summarized in Figs. 1 and 2.

Given these disturbing numbers, it is imperative that we develop a more comprehensive understanding of both the processes that lead to displacement and the consequences for those who are affected. In this special issue we focus on various aspects of the relationship between substance use and displacement. Alcohol and other drug use are now recognized as significant issues among many of the displaced populations discussed above (Fischer and Breakey, 1991; Weiss, 1994; Yee and Thu, 1987) and has captured the attention of the popular news media (Crossette, 1995). Reports of substance use and misuse patterns among several of these groups, however, can actually be traced back several generations.

In the United States, published findings of high rates of alcohol use and alcoholism among homeless males first began to appear around the turn of the century (McCook, 1893; Solenberger, 1911). Subsequent studies, many of them focusing on the "skid row" sections of large American cities, painted similar pictures (Anderson, 1923; Bogue, 1963; Jackson and Connor, 1953; Myerson and Mayer, 1966; Straus, 1946; Sutherland and Locke, 1936). One of the earliest attempts to focus directly on alcohol misuse among homeless persons was Robert Straus' (1946) in-depth study of homeless men in New

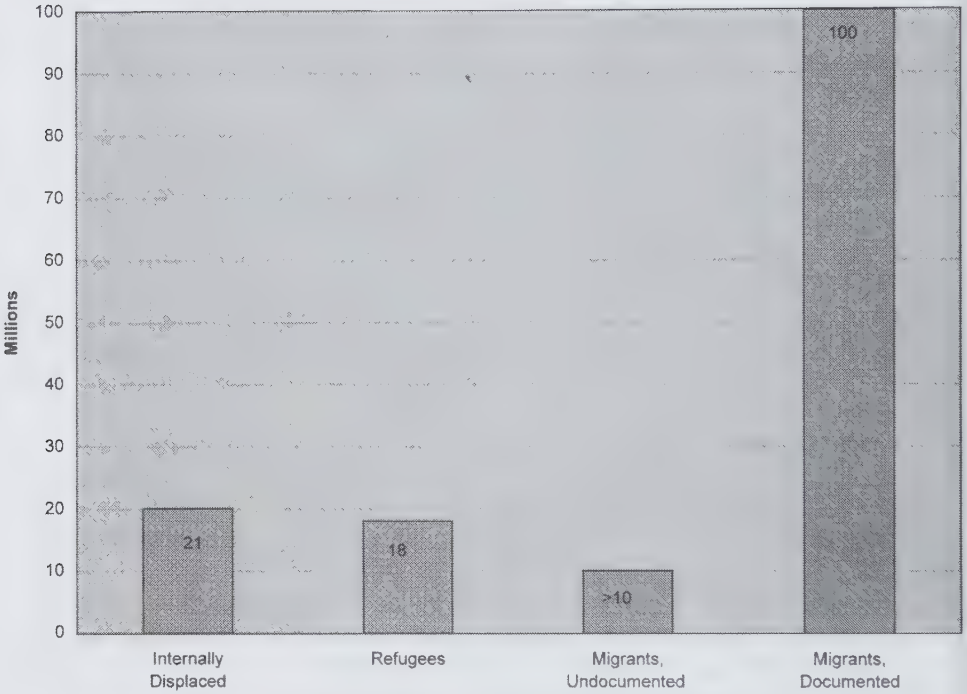

Fig. 1. Estimated numbers of displaced persons. Worldwide: 1995.

Haven, Connecticut. For each person interviewed, Straus attempted to ascertain whether "heavy" drinking preceded or followed the onset of homelessness. He found that, although alcohol misuse appeared to precede homelessness for most (approximately two-thirds), for some, homelessness was a precursor of alcoholism. Working in the Bowery section of New York City two decades later, Howard Bahr and colleagues developed a theoretical framework around disaffiliation, which became influential in understanding the traumas of homelessness, including alcoholism, within the American context (Bahr, 1968, 1970, 1973; Bahr and Caplow, 1973; Bahr and Garrett, 1976). While much of the early literature regarding homelessness and substance use comes from the United States, this topic has also received considerable attention in England (Hutson and Liddiard, 1994; Rose, 1988) and other countries (Glasser, 1994; Herman et al., 1989).

As developed economies have moved into the post-industrial era, the composition of homeless populations in these countries has also evolved. In the United States, minorities, females, and children now collectively represent a majority of what have been referred to as the "new homeless" (Rossi, 1990).

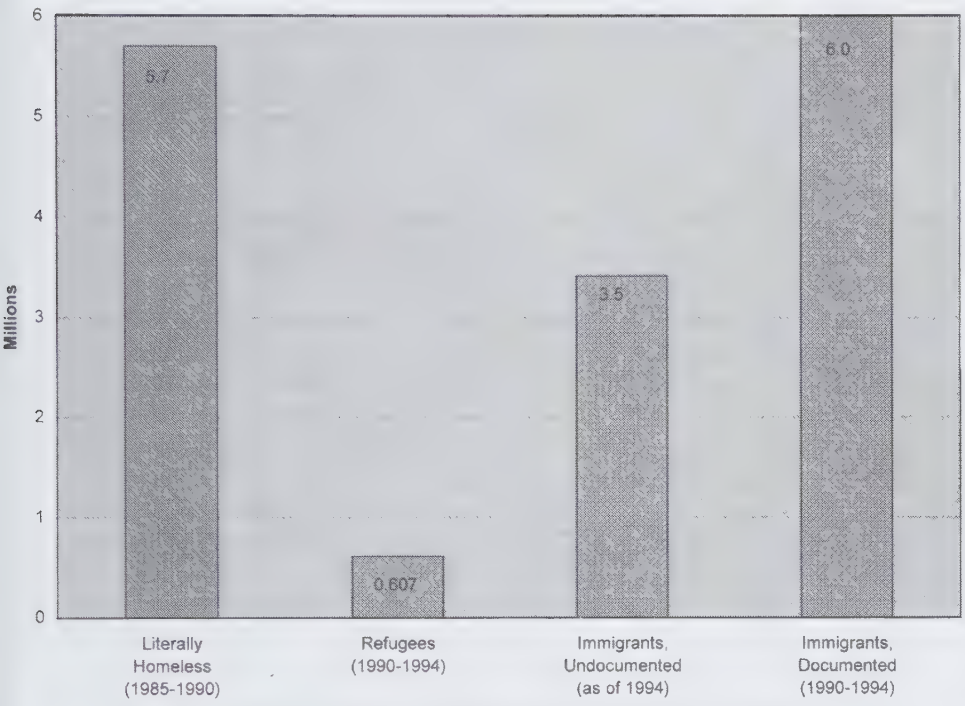

Fig. 2. Estimated numbers of displaced persons. United States: 1985–1994.

In the last fifteen years, drug use and misuse have also for the first time become widely documented among homeless persons (Fischer and Breakey, 1991; Johnson and Barrett, 1995; Milburn, 1989). Some commentators have suggested that the increasing number of homeless persons in the United States during the last decade can in part be linked to the widespread availability of inexpensive drugs, crack cocaine in particular (Jencks, 1994). If and how alcohol and other drug misuse are associated with homelessness, however, remains controversial.

Assessments of substance use among immigrant populations can also be traced back to the early years of this century. In a study conducted in Norway, Odegaard (1932) compared the diagnoses of Norwegian immigrants admitted to the Rochester State Hospital in Minnesota between 1889 and 1928 with those of native-born persons in Norway admitted to the Federal Insane Asylum near Oslo during the same years. After controlling for differences in age distribution, he reported significantly greater rates of admissions from alcoholic psychoses among male Norwegian immigrants in Minnesota compared to males in Norway.

An American researcher who made significant contributions over several decades was Benjamin Malzberg, who published numerous comparisons of native-born and immigrant groups in New York State. In one of his earliest works, Malzberg (1936) found that although crude annual rates of first admissions to New York institutions between 1928 and 1931 for the treatment of alcoholic psychoses were greater among immigrants, the introduction of controls for age and urban vs rural environment erased these differences with the native-born population. Analyzing similar data in New York for the years 1949–51, Malzberg (1964) again demonstrated that, although crude rates indicated higher levels of alcoholic psychoses among foreign-born patients of mental hospitals, age and sex-standardized rates actually revealed higher prevalence among persons born in the United States compared to those having migrated from other countries. Malzberg also noted considerable variability in the prevalence of alcoholic psychoses by country of origin among the foreign born, with persons from Ireland having standardized rates high above average for all groups and those from Russia and Italy having rates far below average. These latter findings provided early evidence that immigrant selection, culture, and experience might moderate subsequent risk of substance abuse.

More recently, social surveys (Chin et al., 1990-91; D'Avanzo et al., 1994; Fernandez-Pol et al., 1985) and ethnographic investigations (Alaniz, 1994; Gonzalez and Page, 1981; Gordon, 1981; Trotter, 1985; Westermeyer et al., 1989) have also been implemented to collect firsthand information regarding the substance use practices of a variety of immigrant and refugee populations. Among the factors that have been implicated as correlates of substance use in these studies are measures of both acculturative stress and assimilation. Indicators of acculturative stress have included loneliness, social isolation, family separation or loss, loss of traditional social roles and/or occupational status, and pessimism or anxiety regarding future economic opportunities. Indicators of assimilation examined in these studies have included length of time in the host country and degree of exposure to host culture. Other recent research suggests that successful integration of both native and host cultures may be more central to the avoidance of substance misuse compared to the acculturation models that have been more widely studied (Liebkind, 1996; Oetting and Beauvais, 1990; Tucker, 1985). Yet, the specific processes that account for substance use within these populations remain open to debate.

ABOUT THE SPECIAL ISSUE

The papers in this issue address several of the unresolved issues discussed above. They use a variety of methodologic approaches to assess issues relevant to substance use among a variety of displaced population groups. Research data

for these papers come from several sources, including social surveys, demographic and vital health statistics, medical records, case studies, and ethnographies. The types of displacement, cultures, and geographic regions represented in this special issue are equally diverse.

The first paper provides an assessment of patterns of inhalant use among street children in Tegucigalpa, Honduras. In this study, Wittig, Wright, and Kaminsky examine how the presence and absence of various socialization processes might influence the development of drug use habits among these youth. Their work is of particular importance because of its attention to substance use in a developing nation now experiencing rapid urbanization and the resulting displacement of large numbers of people as they migrate to urban centers.

D'Avanzo presents an overview of current knowledge regarding substance use and misuse among recent Southeast Asian refugees and immigrants who have resettled in the United States. With sensitivity to the cultural issues involved, she reviews the unique sets of stressors experienced by this group in leaving their native homelands and adjusting to United States cultural influences. Within this framework, D'Avanzo also explores barriers to substance misuse treatment among Southeast Asians in the United States.

A demographic analysis of alcohol-related mortality among migrants to England and Wales is next presented by Harrison, Sutton, and Gardiner. They compare mortality rates among several immigrant populations, including those emigrating from Ireland, South Asia, and the Carribean, and interpret their findings within a framework that considers the structural, economic, demographic, and psychological processes confronting immigrants.

The paper by VanGeest and Johnson is one of the few papers available that simultaneously examines the relationship between substance use and multiple types of displacement. They evaluate several alternative models using information abstracted from patient medical records at a public health care clinic located in Chicago that serves several low income populations, including homeless persons and immigrant groups.

Van de Wijngaart presents a case study of drug use among immigrants and refugees in the Netherlands. In reviewing this country's unique historical context, he examines patterns of migration and drug use and how government policies have evolved to address each. He also reviews treatment issues and argues persuasively that culturally appropriate methods are necessary to properly assist members of minority groups who have addiction-related problems.

Four perspectives thought to be likely pathways to homelessness for adults in the United States are evaluated by Sosin and Bruni using survey data collected in Chicago during the 1980s. They examine the relation of resource inadequacies, social network, disaffiliation, and mental health-related processes to homelessness among persons with and without drinking problems. Their

findings serve as an important reminder of the complexity of the interrelationships between substance use and other processes thought to be associated with homelessness.

The prevalence and correlates of drug and alcohol use disorders among homeless and runaway youth in the Hollywood section of Los Angeles are next explored by Kipke, Montgomery, Simon, and Iverson. The first paper in this volume expresses the growing concern in many parts of the world with substance use patterns among street youth; Kipke and colleagues contribute to this literature by presenting evidence based on standardized diagnostic criteria that provide more precise estimates of treatment needs among these youth.

In the final paper, Jutkowitz, Spielmann, Koehler, Lohani, and Pande present an ethnographic investigation of heroin use among adults and street children in the capitol of Nepal, a country where studies of this nature are very rare. Among the topics they address within this context are changes in traditional family roles and relationships, the social consequences of poverty, and the unique drug-related history of Nepal.

As a collection, these papers instruct us that, although their pathways to displacement may be unique, immigrants, refugees, homeless, and other displaced persons nonetheless share many common experiences. Loss of valued social ties, new socialization demands, economic pressures, rejection, discrimination, racism, and exploitation are but a few. These commonalities may suggest a point of departure for integrating what have been until now separate lines of inquiry into a unified framework for understanding how and under what circumstances displacement may be linked with substance use. It is hoped that this special issue will provoke additional theoretical development and research in this direction.

This special issue has been in preparation for the past two years. I would like to thank a number of individuals who served as ad-hoc reviewers for this special issue and acknowledge their contributions. They include Michael Agar, Richard Barrett, Mark Barrett, Cor DeJong, Michael Fendrich, Thomas Ford, Elizabeth Lambert, Ramin R. Misra, Marjorie Robertson, Barry Spunt, James Swartz, and Joseph Westermeyer. The contents of this issue have greatly benefited from their thoughts and suggestions.

Finally, this volume includes with a brief listing of organizations and other resources that may provide useful information to researchers in this area. This list is far from complete and I would encourage readers with additional suggestions to contact me directly.

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Substance Use among Street Children in Honduras

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ABSTRACT

The hypothesis that drug use among Honduran street children is a function of developmental social isolation from cultural and structural influences is examined. Data from 1,244 children working and/or living on the streets of Tegucigalpa are described, separating "market" children from "street" children. The latter group is then divided into those who sniff glue and those who do not to identify salient distinguishing factors. An OLS regression of drug usage on these variables results in a model that explains 75% of the variance, where family relations, length of time on the street, and delinquency are the most important factors. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Street children; Inhalants; Glue sniffing; Delinquency; Family relations

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INTRODUCTION

An increasing problem of less developed nations is the numbers of *street children* who surround the airports and hotels of most large cities, begging and often stealing to support themselves. This phenomenon continues to receive more attention than analysis. Reports of the violence and abuse suffered by street children comprise a steady stream of horrors, ranging from rape to murder (Gettleman, 1994; Hoffman, 1994; Kayayan, 1993; Moffat, 1994; Salazar, 1994). Scholarly research on the origins, circumstances, and drug usage among this population remains rare (see Table 1), and the studies that are available often disagree on key particulars, including the definition of a street child. Here we examine the data from a large sample of children who must work and/or live on the streets of Tegucigalpa, Honduras, with a focus on their patterns of substance usage (mostly glue sniffing). Although those who are homeless are (presumably) exposed to the same social and cultural influences, the same temptations, and the same opportunities, only about half of these children in our data use drugs occasionally or regularly; the rest report that they never do. What factors account for this variation?

The lives of children who live in and around the streets of Third World cities are unquestionably ones of extreme hardship and vulnerability. Media reports from South and Central America suggest that violence against and abduction of street children continues to escalate, especially in nations such as Brazil and Columbia (de Oliveira, 1990; Hoffman, 1994; Kayayan, 1993; Moffat, 1994; Salazar, 1994). While these threats began with exterminations by market vigilantes, police, and the armed forces, many now also include confrontations between rival drug gangs (Salazar, 1994). Thus, drugs have entered the violence equation in Third World cities as well as in the cities of North America. Little is known about the patterns of drug use in Latin America; a review of studies in Mexico and Brazil reports that solvent use is "exceptionally high" among street children, while elsewhere the "research is quite disparate, making comparisons . . . difficult" (Beauvais, 1992:31).

In a study of street children in five Latin American countries (Brazil, Colombia, Bolivia, Peru, and the Dominican Republic), Lusk (1989:63) finds that most of these children in "urban settings" use drugs varying from marijuana to inhalants, at least occasionally. Lusk (1989:64) also reports widespread and rather serious consequences of drug use in this population, for example, sleeplessness, anorexia, and reduced sensitivity to cold; drug-using street kids are also frequently engaged by drug dealers in their illicit commerce. Connolly (1990:144) agrees that the regular glue sniffers in his Guatemalan sample are distinctive, "easily recognized by their ragged clothing, soiled faces, and glazed eyes, and the effects of brain damage are observable among long-time users."

Contrary results are reported in Aptekar's (1988) evaluation of Colombian

Table 1.

Substance Usage by Street Children in Latin America: Selected Parameters, Processes, and Studies

Author(s) and year	Countries and sample size	Variables examined	Research methods and results
Aptekar, 1988	Columbia, $n = 56$	Alcohol, cigarette, inhalant, marijuana, and basuko (coca leaf residue) usage; age; IQ scores (Bender-Gestalt, Kohs Block Design, and Human Figure Drawing)	*Methods*: Interviews, field observation, and psychological test *Results*: Drug usage has no significant effects on emotional or neurological functioning
Carlini, 1993	Brazil, $n = 912$	Inhalant, marijuana, cocaine, barbiturates, cough syrup, amphetamine-related, and anticholinergic drug usage; age; city; treatment	*Methods*: Review of scientific articles *Results*: Documented cases of emergency treatment for intense psychotic episodes
Connolly, 1990	Columbia and Guatemala, $n \geq 100$[a]	Alcohol, inhalant, marijuana, and bazuka (tobacco and cocaine) usage; age; health risks and delinquency	*Methods*: Interviews and field observation *Results*: Symptoms of brain damage among long-time drug users
Janowsky, 1991	Guatemala and Honduras, $n = 6$	Alcohol, cigarette, inhalant, and marijuana usage; age; sexuality; health status; goals; family life; and abuse	*Methods*: Ethnography and field observation; six taped interviews *Results*: Drug usage related to weakened family relations and personal goals
Leal et al., 1978	Mexico, $n \leq 100$[a]	Inhalant usage	*Methods*: Naturalistic field observation *Results*: Deviance and crime become group norms with drug use
Lusk, 1989	Bolivia, Brazil, Columbia, Dominican Republic, and Peru, $n \geq 500$[a]	Inhalant, marijuana, and coca paste usage; delinquency; abuse; malnutrition rates; intervention programs	*Methods*: Research reviews, document analysis, and field observation *Results*: Street ethics replace family values
Raffaelli et al., 1993	Brazil, $n = 379$	Alcohol and "drugs"; age; gender; sexual behavior; violence	*Methods*: Observation, in-depth interviews, questionnaires, focus group discussions *Results*: Drug usage highly related to sexual activity and disease (HIV)

[a]Exact sample sizes are often unreported in qualitative studies.

street children in Cali, who finds little evidence of pervasive drug usage or the debilities described by other researchers. The results of three psychological tests show that street children in Colombia have IQs within the normal range and that emotional and neurological functions are not affected by the length of time on the streets or by patterns of drug use. In fact, the results of tests for social and psychological adjustment among boys ages 7 to 17, sleeping on the city streets, suggest that street life may have an *accelerating* effect on intelligence. Techniques for measuring street survival skills are now being evaluated (Janniro et al., 1994) but, thus far, replication of Aptekar's study is unreported.

Previous research is also inconsistent with respect to why street children are attracted to or become dependent on drugs. Drug use among these children is frequently claimed (by the children themselves and by some researchers) to provide relief from pain, cold, and hunger. Glue is readily obtainable on the street and is often cheaper than food; "a *high* can be maintained all day with a thirty-cent bottle of shoe cement" (Connolly, 1990:144). At that rate glue sniffing can be highly cost-beneficial and is reported as a significant nutritional risk factor among "hardcore" Filipino street children (Hixon, 1993:376). Nevertheless, the children's claims that their drug use is to assuage hunger or pain are also controversial. "Some children rationalize their drug use as an appetite suppressant while others openly admit to their enjoyment of the intoxicating effects" (Lusk, 1989:64). Whether drug use among these children is thrill-seeking or adaptive (and thus functional) behavior is therefore yet to be determined.

Aptekar (1990) describes a sample of 56 boys living on the street of Cali as cunning, resourceful survivors who drift in and out of the gangs they form for physical strength and emotional gratification. They recruit younger children (considered economic assets by adolescent gang members) for their appeal and success in begging. In response to his assertions that stealing, begging, and drug use are *normal* adjustments to adversity and survival needs, Janowsky (1991:76) states that, while this may be true, it is also true that "the life of a street child is difficult—full of pain and exploitation."

Public attitudes toward street children reflect an impatience with the problem that is also observed in major cities worldwide toward the adult homeless population. As drug use among these children becomes more visible (Carlini, 1993), they are less likely to be defined as a nuisance and more likely to be defined as a danger, thereby promoting aggressive public reactions against them. From Canada to Brazil, the postulated threat to tourism and public health (Raffaelli et al., 1993) has fostered numerous anti-(street)-youth campaigns that range from cuts in support for social programs that serve them to the infamous "death squads" reported by Amnesty International (Moffat, 1994:23). Residents of poor neighborhoods in Brazil, often sympathetic to violence directed toward

"bad children," say nothing when they are attacked or disappear (Scheper-Hughes and Hoffman, 1994:22). Huggins (1991) cites a listener poll by *Radio Globo* in Recife City, where there was "three to one support for youth exterminations" (GAJOP, 1991:21). Comparing national attitudes, Moffat (1994:27) states that in "North America, attempts to help street youth . . . are mostly met with indifference, even hostility if they become too political. In Central and South America, such work can be life threatening." In fact, he reports that a bulletproof vest is routine attire for a Canadian director of Covenant House in Guatemala.

The "street kids" phenomenon, to be sure, is not a simple problem to be solved by increasing the level of tolerance or respect for children. The UN General Assembly first attempted this strategy in 1959 with the Declaration on the Rights of the Child that was translated in 1989 as a "legally binding international instrument—the Convention on the Rights of the Child" (*UN Chronicle*, 1989:51). Among most developing countries that have ratified the convention, implementation of children's rights to protection, education, health, recreation, etc. remains problematic. UNICEF reports from Africa and Latin America state that poverty caused at least half a million deaths among children in a single year, despite the "spectacular advances" for universal immunization and oral rehydration therapy in Third World countries. Citing these reports, the *UN Chronicle* (1989:48) points to income inequality and "crushing external debt" in many of these nations where "average incomes have fallen by 10 to 25 percent" during the 1980s. Janowsky (1991) suggests that the success of the UNICEF/WHO projects in reducing infant mortality with modern medical techniques while failing to lower the birth rates in developing countries has produced the unintended effects of increasing family size, poverty rates, urban migration, joblessness, and, ultimately, the number of street children.

According to Lusk, the repercussions of these and other large-scale structural forces include the development of a stratum of children who adopt a *street ethic* outside of the most important "institutions of socialization—the family and the school. This final stage . . . can be characterized by a fundamental break between the child and society" (Lusk, 1989:61). Isolation from institutions of socialization is seen as a major problem for society and for children who live on the streets. "To the extent to which interactions between the children of the street and members of the larger society occur, they are usually exploitative or predatory" (Lusk, 1989:61). Similarly, such estrangement from normal social institutions and support networks is also a principal source of the rising tide of homelessness in the United States (Wright, 1989). We return to address these issues further in the concluding section of this paper.

In this analysis we confront the contradictory reports and the varied interpretations of drug usage among street children as well as the social and structural effects. This study of over 1,200 street children is, by far, the largest sample now available for research purposes. While most analyses are both anecdotal and limited to runaway, abandoned, or orphaned children, this case study includes children who are working in the streets with a parent as well as those who are living on their own and sleeping in the streets. It is important to examine the contrasts between these two groups, even though none of the former are reported to use drugs, in order to explore the premise of stages of development for street children as described by Lusk (1989).

Our aim here is to examine drug use patterns and implications for Honduran street children as a function of developmental social isolation from cultural and structural influences such as family, education, religion, and support networks. Thus, the main hypothesis is that the most isolated street children are more likely to use drugs and also to engage in other acts of deviant behavior as a reflection of their lack of access to other means of gratification rather than cultural attributes or other background factors.

DATA AND METHODS

The study is based on an analysis of data collected (1990–1992) from street children and their mothers in and around the street markets in the capital city of Honduras, Tegucigalpa. The primary instrument is a protocol, or baseline survey, for clients for *Proyecto Alternativas*, a health education and social services program supported by UNICEF, the Pew Charitable Trusts, and other nongovernmental organizations (NGOs). The research component for the project combines the efforts of the School of Public Health and the Department of Sociology at Tulane University. These data have been carefully collected by *street educators* who are selected and trained by the director of the project (see Appendix). Most are young primary school teachers, and many study at the nearby University at night, majoring in social work, law, or medicine. Due to the high rate of "burn-out" in this stressful assignment, the average length of service is two to three years. Designation of potential clients relies on the United Nations' definition of a street child:

> Any girl or boy . . . for whom the street (in the widest sense of the word, including unoccupied dwellings, wasteland, etc.) has become his or her abode and/or source of livelihood; and who is inadequately protected, supervised, or directed by responsible adults (ICCB, 1985).

UNICEF and we make a distinction between children "in" the street and those "of" the street. Those in the former category remain close to their family (often

working with them in the street markets), while those in the latter group are frequently abandoned, orphaned, or runaway children who consider the streets to be their home, although they may still have family contacts.

Street educators meet the children *on their own ground*, that is, all the health education, nutrition, recreational, and primary health care interventions of the project are delivered in the streets and markets where these children work and/or live. The primary goal is to establish *rapport* with the children and their families (where appropriate) so that basic lessons in sanitation and health care can be offered in an atmosphere of confidence and trust. The project operates daily in each of five street markets and a recreation center in the city center frequented by teenagers. A team of two (one male and one female) street educators is assigned to each location and is joined by a physician, a nurse, a psychologist, and a social worker on an alternating weekly schedule (one day a week in each location).

Each child represented in the data analyzed here was interviewed approximately four times before the baseline data protocols were completed by street educators using field notes and the assessments of the clinical team. In most instances where there was a parent or family member responsible for the child, this adult was also interviewed for further information as well as for consent. Identification codes were assigned designating families by numbers and the parents and siblings by letter. The selection of the sample for the survey was based on the perceived medical and health needs of poor children and their families in the streets and markets. The five markets where the project operates, four in the city center and one at the outskirts, were chosen in order to reach a diverse sample of the "poorest of the poor," those most in need of health care and health information (Kaminsky, 1992).

Despite the diversity of locations from which project beneficiaries were recruited, the sample remains purposive, not probabilistic. The sample also contains a "snowball" element in that siblings of initially recruited subjects are also included. Both children "in" the streets—market children working with their families—and children "of" the street—mostly runaway or abandoned children living on their own—were interviewed. Since the primary health care and education offered by the project is otherwise virtually unavailable to this population, recruitment of clients is relatively simple. Market mothers are eager for an opportunity to improve their children's welfare, and street children are hungry for attention, as well as food. The total sample comprises 1,244 children interviewed over a period of approximately two years. Of these, 1,084 are *market* children and 160 are *street* children, based on the classifications of the street educators (see Appendix). The average age for *market* children is 10 years; 53% are boys and 47% are girls. The average age for *street* children

is 13 years and 95% of them are boys. Thus, across the entire sample there is a preponderance of males (58%) over females (42%).

The information obtained in the baseline protocol includes the usual demographics (age, sex, birthplace, marital status of parents, etc.) and a number of more specialized questions tapping the unique concerns of this population—their usual sleeping places, whether they have a caretaker in the streets, their relationships with their families, and whether or not they are orphans. Other questions include religious affiliation, school attendance, means of making money, whether money is shared with family, reports of arrest, imprisonment, harassment by police or market vigilantes, gang membership, and drug usage. Assessments (poor, fair, good, excellent) of mental and physical health, nutrition, and survival skills were also made by the educators, under the advise and supervision of the project director. Obvious signs of psychosis, chronic depression, antisocial behavior, adjustment disorders, cognitive impairment, and mental or family dysfunction were also noted (see Appendix). Other questions concern access to health care, frequency of shelter usage, number of regular daily meals, sexual activity, prostitution, and treatment for sexually transmitted diseases.

LIFE ON THE STREETS

As we have already indicated, there is an important distinction between children "in" the street and children "of" the street. The latter are the typical "street kids" (runaway, orphaned, or abandoned children), living on their own without adult supervision or support. Children "in" the street are often referred to as "market children"; they live with their parents (almost always the mother and sometimes an adult male who may not be the father). They work in the markets, vending, watching younger siblings, doing odd jobs; some attend school part time. While their life circumstances are irregular and they are often extremely needy, it is the child "of" the street that has been in the forefront of public discussion about the "street kid" problem.

About 90% of the beneficiaries of *Proyecto Alternativas* are market children; the remaining tenth are typical street children. Table 2 displays some of the obvious contrasts between the two groups. Compared to market children, street children are older and almost exclusively male, considerably less likely to have been born in Tegucigalpa (a large minority are recent migrants to the city), much more likely to report "poor" family relations, more likely to be orphans, and much less likely to be attending school. Nearly 60% of the "street kids" earn money by begging or stealing vs about 5% of the market children; nearly half the former have been arrested by the police vs less than 1% of the latter. Street children are also *much* more likely than market children to be

Table 2.

Preliminary Comparisons between Street and Market Children in Tegucigalpa, Honduras (1990–1992) for Selected Variables

	Street kids	Market kids
N	160	1084
Demographics:		
Mean age (years)	13.1	9.9
Percent male	94.4	52.7
Percent born in Tegucigalpa	60.5	83.3
Family, school relations:		
Percent with family relations assessed as "poor"	37.7	2.9
Percent orphans	6.7	1.7
Percent who attend school	7.8	47.1
Deviant behavior:		
Percent who earn money by begging or stealing	58.2	4.7
Percent ever arrested by police	47.4	0.7
Percent who belong to a gang	27.4	1.9
Percent who are sexually active	51.3	5.4
Substance use:		
Percent who sniff glue	53.2	0.8
Percent who drink alcohol	43.1	3.9
Percent who smoke cigarettes	56.7	4.9

involved in gangs, to be sexually active, and to use drugs. Among street kids, cigarettes and glue are the drugs of choice, although nearly half (43%) also use alcohol. By these measures—drug use, petty crime, gang activity—"bad children" are clearly overrepresented by street kids.

Children actually living in the streets of Tegucigalpa experience excitement and danger, challenges, and various forms and amounts of support. Freedom from adult control and constraint is perhaps the principal allure. The dangers include foul weather, city traffic, and the threat of abuse from police, adults, and older street children. Food and a viable place to sleep are daily challenges. Minimal support is provided by other street children, loosely formed gangs, sympathetic merchants, formal shelters, and various outreach and social service programs organized by NGOs, international groups, or the Honduran government. Some of the six major programs and shelters are supported by religious organizations and are viewed with suspicion by street children who resist their reform agendas as well as the institutionalization and control that they associate with government programs.

Street life is something that children may be drawn into over a period of time (as opposed to a condition into which they are suddenly thrust by some familial or economic crisis). Often they are market children who have temporarily stopped going home at night, perhaps because they missed their bus or their friends persuaded them to stay out and experience the thrill of being on their own. For children who are compelled to work all day in the streets and markets and then go home at night to still more work in the household or to outright abuse, the appeal of a "carefree" life of reckless abandon among their peers can be powerfully seductive. Thus, many children alternate between home and the streets for quite some time, staying on the streets for longer periods, learning to travel the city and negotiate the hazards; eventually they become full-time street children (Lennox, 1992:36).

The dangers of life on the city streets emerge gradually as the nights turn cold and wet or hostile encounters arise. While Tegucigalpa has a cool, dry climate most of the year, the rainy season brings street flooding and damp, cold nights that persist for weeks. Children who may have found refuge under one of the city's bridges must now compete with other groups for shelter. Competition for space and food often results in fights and wounds from knives or broken bottles. The euphoria that glue-sniffing children obtain is described by researchers as similar to that from alcohol in that it promotes disturbances of behavior (Flanagan and Ives, 1994); it also invites the disdain of the general public and abuse from police and other adults.

Finding food and shelter each day are only the most obvious challenges of street life; others include eluding authorities, manipulating merchants, shoppers, and tourists, and dealing with physical and emotional stress. In their search for food, many children resort to begging outside restaurants or eating from the discards found in dumpsters. Others find "momentary jobs, such as watching over a parked car or unloading or transporting boxes and packages" (Lennox, 1992:37). Some simply steal food, money, or merchandise that they can trade or sell. While police in Tegucigalpa tend to ignore begging and panhandling, stealing definitely commands their attention.

The relief or support available to street children comes from their peers, benevolent vendors and merchants, formal shelters, street educators sponsored by NGOs, and government outreach programs. To support one another, children often form small gangs that travel the city and stay together at night, sometimes pooling their money to buy *Resistol*, the preferred brand of glue for sniffing. The solvent used in this glue is toluene, and the company producing it has considered various methods of restricting its misuse (Bowie and Lenway, 1990). *Resistol* is now sold in large containers to reduce its availability to children, but smaller quantities of the product are available from street sources. Whether from indifference or profit motive, shoe-repair vendors often assist

the children in buying the glue they want; other vendors may give them left-over food or odd jobs. Shelters for street children vary in services and in requirements for participation; some offer food, beds, and showers on a walk-in basis, while others insist on a long-term commitment to reform, especially aimed against drug usage. All of the programs discourage glue sniffing; street educators from *Proyecto Alternativas* sometimes trade a sandwich for a *resistolero's* glue container (usually a paper juice carton) which "is then burned on the street in front of him" (Grant, 1993:8).

Although the effects of glue sniffing are often the source of their problems with the police and with other unsympathetic adults, most street children who sniff glue do so quite openly. The addictive potential of inhalants such as glue solvents is still under investigation (Yavich et al., 1994), but the temptation is powerful, especially as a means of identifying with their friends in the streets (Grant, 1993:8). Being intoxicated on glue provides relief from the concerns of day-to-day survival and allows even the older boys to lapse into childish behavior; it may diminish hunger and pain as well. It also fosters a strong present-time orientation; any "plans for tomorrow" yield quickly to the euphoria of the moment (Janowsky, 1991:49).

FACTORS THAT PREDICT DRUG MISUSE AMONG CHILDREN OF THE STREETS

Why do some children of the street seek to bolster their identity and level of comfort by sniffing glue while others do not? Among the typical street children in our data, only about half (53%) use glue. While virtually *all* street kids are exposed equally to the "street culture" and face largely identical survival issues, they obviously respond to these exposures and issues in very different ways, unlike those reported in Mexican subcultures (Leal et al., 1978). What factors account for this variation?

One possibility, to which we refer as the "cultural hypothesis," would be that the early childhood backgrounds and socialization of children who join gangs, sniff glue, smoke cigarettes or marijuana, drink alcohol, or engage in other forms of deviance are fundamentally different from those of other, equally deprived, street children who manage to cope without drugs. Another possibility, to which we refer as the "structural hypothesis," is that degrees of deprivation and isolation exist even among an impoverished group such as street kids and, thus, children who have been on the streets longer or those who have less contact with their families or other adults will be more likely to use drugs. These, of course, are not mutually exclusive possibilities; both sets of factors may operate simultaneously.

In order to explore these possibilities, Table 3 divides the typical street children in our data into two groups, those who use glue and those who do not, and then compares the differences between the groups on a variety of potentially relevant variables. The number of children in this analysis is 156; 4 cases are lost from the original 160 because of missing data on the questions concerning glue use. There are a total of 83 children in the data who use glue regularly or occasionally. For the record, "occasional" use is rare, observed among only 9 of the 83 glue-using street children.

The mean age for nonusers is 12 years and for users 14 years, so the users are two years older on the average. Nonusers have slightly *less* education than the users, probably reflecting the age difference. The average daily incomes of the two groups are also broadly similar; in United States currency, the daily average is about 60 cents for nonusers and 75 cents for users. Importantly, this suggests that the difference between the two groups in drug use patterns is probably not explained by their respective ability to buy glue; a day's supply of glue would represent about 50% of the average daily income of nonusers and 40% of the average daily income of users, not a substantial difference. Contrary to our expectations, nonusers report that they eat only slightly more regularly than users (1.8 meals per day vs 1.6) and tend to come with somewhat larger families (4.0 vs 3.6 siblings on the average). With the exception of the difference in age, none of the other differences discussed in this paragraph strike us as large or substantively meaningful.

On the other hand, the glue-sniffing children have accumulated about twice as many months living in the streets (42.3 months on the average) as the nonusers (22.9 months), a difference whose magnitude corresponds roughly to the difference in age. This is suggestive evidence that glue sniffing is a *developmental* response to a street existence; the longer children are exposed to the environment and culture of the streets, the more likely they are to become involved with drugs. In other words, in this context, substance misuse is probably a *consequence* of street existence, not a *cause*.

Glue sniffing is also exclusively a male phenomenon in these data. There are very few girls to be found among the typical street children, and all of them fall into the nonusing group. Users are also much more likely than nonusers to have been born outside Tegucigalpa and thus to be recent migrants to the city, an initial indication that relative degrees of social isolation may be important factors in explaining patterns of substance misuse in this population.

Further support for the latter hypothesis is also suggested by the data in Table 3 on family background and relationships and social integration. About 63% of the nonusing street children come from single-parent households in contrast to 74% of the users; family relationships are assessed as "poor" for 21% of the nonusers but 56% of the users. About one-fourth (26%) of nonusing children have someone who looks after them in the streets (often an older

Table 3.

Comparisons between Street Kids Who Use Glue and Those Who Do Not in Tegucigalpa, Honduras (1990–1992) for Selected Variables

	Children not using glue	Children using glue
N	73	83
Demographics:		
Mean age (years)	12.0	14.0
Mean education (years)	2.0	2.4
Mean daily income (Lempiras)	4.8	6.0
Mean, regular meals per day	1.8	1.6
Other children in family	4.0	3.6
Average time in streets (months)	22.9	42.3
Percent male	88.0	100.0
Percent born in Tegucigalpa	72.5	50.0
Family:		
Percent with single parent	62.8	74.1
Percent with "poor" family relationships	21.0	56.1
Percent with a "caretaker"	26.0	4.8
Percent who sleep in street	32.8	82.9
Social integration:		
Percent with no religion	65.0	89.6
Percent with no education	34.7	30.8
Percent unable to read and write	45.7	39.2
Deviance:		
Percent who steal to make money	2.7	20.5
Percent who are members of gangs	7.2	46.1
Percent reported being hassled by police	17.1	78.0
Percent ever arrested	18.3	73.8
Percent ever in jail	13.0	68.4
Substance use:		
Percent who drink alcohol	5.6	76.5
Percent who smoke cigarettes	16.9	90.2
Percent who smoke marijuana	1.4	29.3
Level of functioning:		
Percent assessed as "fair" or "poor" in:		
Physical health	17.8	27.8
Nutritional status	20.5	28.9
Mental health	5.5	28.9
Percent who have *never* received medical care	1.6	12.5
Percent who use shelters regularly or often	15.7	74.1
Percent sexually active	31.9	68.8
If sexually active:		
Percent who prostitute	26.3	64.1
Percent ever treated for sexually transmitted disease	54.5	78.2

sibling) as compared to only 5% of users. Finally, of the group not using glue, only 33% say they actually sleep in the streets as opposed to 83% of the glue-sniffing group. Even among this population of typical street children, in short, there is considerable variation in the degree of social and familial support and protection that each receives, with the glue-sniffing children less likely to receive such support on every indicator.

The observed difference in the proportions who actually sleep on the streets is especially striking and revealing. The large majority of nonusing street children evidently retain sufficient social resources that they are at least able to arrange for adequate overnight shelter; the large majority of glue-sniffing street kids clearly do not. It is perhaps also of some relevance that more of the nonusers claim *some* religious affiliation than do the glue-sniffing children.

As would be expected, glue sniffing is also associated in these data with a wide variety of ancillary deviance. Compared to the nonusers, street children who use glue are also much more likely to steal to make money (20% to 3%), to belong to gangs (46% to 7%), to report having been harassed by the police (78% to 17%), to have been arrested (74% to 18%), to have spent time in jail (68% to 13%), and to use other drugs as well. Rates of alcohol, cigarette, and marijuana use are all very much higher among the glue users than the nonusers.

Thus, there appear to be distinct differences in both past and present social influences between children who sniff glue and those who abstain. The contrast in education and literacy is the least sharp, probably because the glue users are two years older on the average. The comparison of the two groups on their formal religious affiliation, on the other hand, suggests possibly important background differences. Although only a speculation, it is possible that the greater religiosity of nonusers could have some impact on their low rate of theft and possibly their access to real jobs. The large differences in involvement with the police and detention in jail are most likely the result of the higher incidence of theft and gang membership for the kids who sniff glue.

In general, "level of functioning" is lower for glue users than nonusers. Based on street-educator assessments, users have poorer physical health, poorer mental health, and worse nutritional status than nonusers. One in eight among the user group has *never* received medical attention; among the nonusers the corresponding figure is less than one in fifty. Use of overnight shelters as an alternative to sleeping in the streets is much more common among the users than nonusers (74% to 16%), probably because the nonusers are more successful in locating overnight sleeping accommodations in the first place. Users are more likely to be sexually active than nonusers (64% to 26%), and among those who are sexually active, users are more likely than nonusers to be involved in prostitution and to have been treated for sexually transmitted diseases.

Street children who sniff glue are thus 65% more likely to have physical health problems than their nonusing counterparts, five times more likely to suffer "fair" or "poor" mental health, six times more likely never to have received health care, and more than twice as likely to be sexually active and to engage in prostitution.

In order to test the significance and relative importance of some of the major factors identified here, we perform an OLS regression of drug usage among typical street children on age, sex, place of birth, parents' marital status, length of time in the street, literacy, religious affiliation, sleeping arrangements, caretaker in the street, work sector, income, criminal behavior, family relations, and shelter usage. A scale for drug usage is designated as the dependent variable, where never = 0, occasionally = 1, and regularly = 2 for responses to questions about the use of glue, alcohol, cigarettes, marijuana, cocaine, and intravenous drugs. By adding these values, the range on this scale is 0 to 8, as there are no positive responses in these data to the use of cocaine or intravenous drugs.

The independent variables in model #1 represent selected demographics, including age, sex (male), place of birth (outside city), length of time in the street (days), and parents' marital status (married or living together). In model #2, cultural influences include variables for religious affiliation (yes), literacy (yes), sleeping arrangements (Barrio or Colonia), and caretaker presence (yes). The structural effects, entered in model #3, include a health scale comprised of the street educator assessments of clients' mental, physical, and nutritional health (1 = poor, 2 = fair, 3 = good, 4 = excellent), thus the range of this addictive scale is 3 to 12. A scale for work sector codes first responses to the question: "How do you make money?" into 1 = begging, stealing, prostitution; 2 = washing cars/windshields, guarding cars, running errands, carrying cargo; 3 = shining shoes, selling newspapers or trinkets, scavenging; 4 = market employment. This scale (ranging from 1 to 4) represents an assessment of informal to formal work. A crime scale is computed by adding responses to questions about arrest, incarceration, harassment by police, harassment by market vigilantes, where never = 0, once = 1, several times = 2, many times = 3; the range is 0 to 12. Other variables in this model consist of reported amount of daily income, self-evaluated family relations (1 = poor, 2 = fair, 3 = good, 4 = excellent), and frequency of shelters usage (0 = never, 1 = several times, 2 = many times, 3 = regular).

Table 4 displays the beta weights and significance for the variables and the adjusted R^2 for each model. In model #1, where demographics for age, sex, place of birth, time in street, and parents' marital status are compared for effects on drug usage, length of time in the street is clearly the most important factor, followed by and correlated (.41) to age. While place of birth is

Table 4.

Results of OLS Regression of Drug Usage[a] among Street Children on Age, Sex, Place of Birth, Parents' Marital Status, Time in Street, Literacy, Religious Affiliation, Sleeping Arrangements, Caretaker in Street, Work Sector, Income, Crime Scale, Family Relations, and Shelter Usage. N = 106

Variables	Models		
	Selected demographics	Cultural influences	Structural effects
	beta	beta	beta
Demographics:			
Age (years)	.278**	.238*	.043
Sex (male)	.117	.093	−.038
Place of birth (not city)	.197*	.104	.076
Time in street (days)	.303***	.294***	.268***
Marital status of parents (not single)	−.104	−.036	.005
Cultural influences:			
Religion (none)		−.131	−.139
Literacy (yes)		−.134	−.061
Sleeping arrangements (barrio/colonia)		−.278**	.016
Caretaker in street (yes)		.048	.002
Structural effects:			
Health scale (3–12)			−.086
Work sector (1–4)			.041
Crime scale (0–12)			.580***
Daily income (limpera)			−.039
Family relations (1–4)			−.237**
Shelter usage (0–3)			−.001
Adjusted R^2	.344	.406	.747
F Ratio	12.116***	9.063***	21.936***
Degrees of freedom	101	97	91

[a]Dependent variable. Omitted categories: Sex = Female, Birthplace = Tegucigalpa, Parents marital status = Single, Literacy = Cannot read or write, Religion = No affiliation, Caretaker = None, Sleeping arrangements = Street/market/institution/other.
*$P < .05$, ** $P < .01$, ***$P < .001$.

significant in this model, when cultural influences are entered in model #2 only length of time in the street, a regular place to sleep, and age are statistically significant, in that order. This model also improves the amount of explained variance from 34% to more than 40%. Model #3, which adds structural effects, retains significance only for length of time in the street, while the most important factor associated with drug use is crime or encounters with authority. The self-reported quality of family relations is also significant, but less

important than the other two factors. With the final model, almost 75% of variance associated with drug use is explained.

DISCUSSION

The primary factors that distinguish children of the street who use drugs from those who do not, controlling for variables that initially hold significance (age, place of birth, and sleeping arrangements), are their encounters with authority, the length of time they have spent on the streets, and the quality of their family relations. Correlation, to be sure, is not causation; some of the differences noted in this analysis are likely to be causes of substance use and others are probably effects, and the data themselves cannot tell us which is which. In important respects, drug usage appears in these data to be part of a developmental process—the process of being socialized into the street culture by peers, one that also includes petty criminality and decay of family relationships as its signal features; a frequent finding in research on inhalant use (Oetting and Webb, 1992).

Numerous studies in the United States have examined the link between drug use and criminal activity among adolescents and conclude likewise, namely, that involvement in crime often *precedes* drug use and that "the relationship between drugs and crime is developmental rather than causal" (Bureau of Justice Statistics, 1992:4; see also Akers, 1992; Huizinga et al., 1989; Johnston et al., 1978; Sheley et al., 1993). In short, it is not as though young people get involved first in drugs and are thereby led to crime or other forms of deviance, but rather that getting "high," hanging out, forming gangs, and becoming involved in petty criminality are all part and parcel of the street culture, with no one element of that culture causally prior to any other.

Concerning "cultural" vs "structural" explanations of drug use among street children, both sets of factors appear to be of some importance. Cultural factors such as having a regular place to call home appear to have important effects, but so too do various other factors such as migration to the city, time accumulated on the streets, and quality of family relations. It is clear that isolation from and repression by adult society are important factors that put kids on the streets and that promote drug use once there. Whether these should be labeled as "structural" or "cultural" influences is debatable and probably not very important.

While some have argued that street life and drug usage represent actively positive choices for these children, their isolation from society and persecution by police suggest a lack of alternatives as a more likely explanation. No one who has spent any time with these children can possibly believe that they have actively chosen a life of extreme deprivation, abuse, persecution, exposure,

illness, and, frequently, an early and violent death in preference to some realistically attainable alternative existence. Many street children, and even many drug-using street children, have well-developed survival skills and "street smarts" that permit them to endure the hardships faced in their daily lives; and likewise, for many, the streets may be in fact a preferable "alternative" to the continued abuse and exploitation that they would otherwise experience at home. But to say that many of these children have accommodated to the cards life has dealt them is *not* to say that they are actually happy with the hand.

What does our analysis suggest about programs of assistance or intervention for street children in the less-developed world? First, the overall situation of street children puts them at greater risk than the situations faced by the larger group of market children. Within the street kids category, the drug users appear to be the most disadvantaged subgroup by far, indicated by their isolation in the street, problems with authorities, and lack of family support. This finding is consistent with research on drug use among Hispanic youth (Gfroerer and De La Rosa, 1993) reporting that the influence of the mother and her attitudes toward drugs are far more important than the family structure (single vs two-parent households) in influencing children's behavior. Compared to findings in a longitudinal analysis of drug use patterns among Anglo-American and Hispanic-American youths (Coombs et al., 1986) that report age as the critical factor linked to drug usage but not necessarily as a developmental process, our analysis suggests otherwise.

Although Lusk's developmental model for street children cannot be directly tested with these data, the implications for intervention policy are strong. Among the categories of intervention discussed by Lusk, what he calls "preventive" approaches seem to offer the best hope for a genuine solution. Critically, these approaches provide social services to support the family system and therefore intervene *before* children are driven into the streets and into a street culture that promotes drug use. Preventive approaches focus on the "intermediate causes of child displacement" and attempt to address "fundamental causes such as unemployment, low wages, and inadequate housing" that cause families to disintegrate and children to drift into a street existence (Lusk, 1989:74).

Lusk concludes, and we agree, that the emphasis of interventions should be on family support, especially since most street children, even the drug users, maintain contact with their families, at least in the beginning. Only a small minority of those who become socialized into street culture benefit from rehabilitative or correctional strategies. Further, once children "of" the streets become addicted to inhalants, the resistance to treatment is said to be excessive, and "many drug treatment facilities refuse treatment of the inhalant abuser" (Rosenberg and Sharp, 1992:121). Interventions that might help to "maintain the autonomy and integrity of families" and thereby prevent the

children of these families from drifting into the streets include "community kitchens, cooperative day care centers, artisan cooperatives, family planning clinics, and small business services" (Lusk, 1989:74–75).

Connolly (1990:147) cautions that "as long as governments fail to respond to human need by ignoring the socio-economic causes of marginality, more children will be forced to roam the streets." Programs that support families and attempt, thereby, to prevent homelessness and drug use among children are themselves ameliorative measures more than ultimate solutions. Unfortunately, the less developed nations of the world lack the resources to respond effectively to the "socio-economic causes of marginality." The structural adjustments and austerity measures that many Latin American countries have been required to enact in order to service their external debt make the 1980s a "lost decade" (Hayes, 1989). These measures are sometimes presented as temporary sacrifices made for the sake of modernization and long-term economic development (COIPRODEN, 1993). This point of view, however, ignores or glosses over the devastating effects that Third World indebtedness visits on the well-being of children (Bradshaw et al., 1993).

Unfortunately, political and economic realities will not change based on an analysis of street children. Funding for evaluations of projects and programs serving street children is virtually nonexistent, as funding for the programs themselves has become tighter (Rocky, 1993). A statement that this type of research is needed rings hollow when economic priorities are focused elsewhere, and political leverage is one of the many things these children lack. Surely, there are things in this world other than money that are worth saving, and just as surely, the children of this world are among them.

APPENDIX: STREET EDUCATORS AND ASSESSMENTS

To avoid issues of bias in the data, the ID numbers of typical street children, who spend all or most of their time on the street, are recorded separately from those of market children, and a list of these numbers is then supplied with the surveys for analysis. Since "street kids" are the most suspicious and elusive group, only well-trained, experienced, street educators are assigned to work with them. Whether or not they use drugs, they are often quite aggressive and proud of their independence of adult supervision. Once a street educator has won their confidence, they often refer friends who are also eager for the opportunities the project offers (medical care, counseling, recreation, and possible financial assistance). Coordination with other programs or shelters sometimes identifies children who need outreach services, especially an adult to call upon at any time.

The educators are recruited by age (under 30) and interest in the general welfare of children (preference to primary school teachers). They are trained by the director of *Proyecto Alternativas* and advised by the clinical staff (physician, nurse, psychologist, and social worker) in their assessments of the children's physical, mental, and nutritional status. To confirm the reliability of these assessments, log-linear analyses were performed for obvious correlations (such as number of daily meals and nutritional status). Only one instance produced an indication of bias; that between divorced parents and family dysfunction. On questioning the educators about this finding, they freely conceded an inclination to inform the latter attribute by the former response. In a population where common-law arrangements are the norm, family dysfunction based on divorce is problematic. While this variable was excluded from the analysis as well as related evaluations (of psychosis, chronic depression, antisocial behavior, adjustment disorders, cognitive impairment, mental dysfunction), the latter were used to form a scale for "manifest" social problems which correlates highly with isolation from the more formal work sector (data not included).

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Southeast Asians: Asian-Pacific Americans at Risk for Substance Misuse

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ABSTRACT

Projections indicate that by the year 2000 over a million Cambodians, Laotians, and Vietnamese will be living in the United States. There is sparse information relative to the use of substances by these groups due to the absence of national prevalence data. The combined stressors that these refugee groups have faced puts them at high risk for substance misuse. Southeast Asians infrequently use substance misuse and mental health services, which has been perceived as a lack of need for services by these groups. In reality, there is a critical shortage of culturally-appropriate treatment and intervention programs as the prevalence of substance misuse increases in these populations. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Asian; Southeast Asian; Refugees; Substance misuse/dependence

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INTRODUCTION

Prior to 1975, Southeast Asian migration to the United States averaged between 1,500 to 4,700 individuals per year. After the end of the Vietnam War in 1975, however, a dramatic increase in migration occurred. At the present time, over a million Southeast Asians, most of them refugees from Cambodia, Laos, and Vietnam, have been granted asylum in the United States (Takeuchi and Young, 1994). The prevailing stereotype is that Asian Pacific Americans experience few substance misuse problems as compared to other racial or ethnic groups (Sue and Morishima, 1982; Sue et al., 1979; Trimble et al., 1987). Rapid growth of the Southeast Asian population, however, has been accompanied by psychological trauma, economic hardship, and difficulties with acculturation. As a result, available data estimates on substance use in this population may be grossly underestimated (Zane and Kim, 1994).

MIGRATION TO THE UNITED STATES

The majority of Southeast Asian refugees migrated in two distinct "waves." The first, from April 1975 to December 1977, occurred after the fall of Saigon when comparatively educated and affluent Vietnamese sympathetic to the United States and/or the South Vietnamese government left their country. More Westernized to begin with, they adapted to Western culture more readily than later arrivals. Also in 1975, the Khmer Rouge regime took control from the Lon Nol government in Cambodia, beginning a reign of destruction and terror. The regime systematically destroyed the monks, the educated business and community leaders, and the affluent (Kinzie et al., 1984). Often compared to the Jewish holocaust, millions were killed by starvation, torture, and execution. Cambodians fled across the border into Thailand or attempted to reach Hong Kong or Malaysia by boat. The war in Vietnam and the conflict in Cambodia overflowed into Laos, creating an exodus from that country as well; particularly by the Highland Laotians (Hmong) who had assisted American military operations during the war.

The second "wave" of migration from 1978–1980 was in response to continued war and economic hardship in the region. In 1979 the Khmer Rouge in Cambodia were overthrown by the Vietnamese, setting off another exodus. These were frequently country people living at a subsistence level with virtually no knowledge of the outside world, such as Cambodian survivors of the Khmer Rouge regime and the Vietnamese occupation. The majority of Southeast Asian refugees in the United States reside in California, but sizable concentrations also exist in other states such as Washington, Texas, New York, New Jersey, and Illinois (Office of Refugee Resettlement, 1991).

PROBLEMS FACED BY SOUTHEAST ASIAN REFUGEES

The majority of these refugees, especially those migrating in the second "wave," were ill-prepared for life in Western culture, and many have found the transition to be extremely difficult and stressful. Their job skills are inappropriate to an industrialized economy, and previous illiteracy has contributed to inadequate learning and comprehension of English. Large family size, survival guilt, and expectations of financial support from friends and relatives in their countries of origin have created additional stressors. The majority have endured war, the destruction of their possessions, homes, and country, and separation from, as well as the death of, family members and friends. As a result of these traumatic experiences, a considerable number of Southeast Asian refugees have displayed severe psychiatric and social symptoms such as nightmares, confusion, memory loss, poor concentration, withdrawal, forgetfulness, nervousness, depression, and feelings of isolation (Kinzie et al., 1990). This constellation of symptoms has been labeled Post-traumatic Stress Disorder (PTSD) and has received considerable attention in the literature (Boehnlein et al., 1985; Mollica et al., 1987). Cambodians are believed to have endured the most devastating hardships and resulting psychological stress of any Southeast Asian group. Based upon the American Psychiatric Association's psychosocial stressor severity classification for mental disorders, they are the most traumatized (Kinzie and Fleck, 1987).

Because expression of emotions is discouraged culturally, emotional stress is frequently expressed in somatic terms as physical problems for which they seek medical help. Somatization is a "face-saving" mechanism used to gain assistance for emotional problems they dare not express (Mattson, 1993). Because what is verbalized is frequently different from the underlying problem, Southeast Asians are often an enigma to American health care providers (Falvo and Achalu, 1983; Rosenberg and Givens, 1986).

This author's work with refugees entails visits to their homes. Contrary to the common stereotypes of Asian educational and economic success, Southeast Asian refugee families, friends, and acquaintances often crowd together in small apartments where they sleep and eat on mattresses or mats on the floor. Gas stovetop burners may be used as a dangerous alternative to inadequate heat. Many are transient and unconnected to services such as health care, thus creating a sense of hopelessness. In addition, they may be discriminated against by individuals who perceive them as a drain on community and federal resources. This is particularly true in areas where large groups of Southeast Asians reside, where the influx of these populations has sometimes changed the ethnic identity and social structure of entire regions.

Projections indicate that by the year 2000 over a million Cambodians, Laotians, and Vietnamese will be living in the United States (US Bureau of the Census, 1990). There is sparse information relative to the use of substances by these groups, however, due to the absence of national prevalence data (Austin et al., 1989; Trimble et al., 1987). Stress, such as the combined stressors of loss, illiteracy and poverty, has been imputed to be a precursor to "substance abuse" (Sue et al., 1985; Yee and Thu, 1987; Zane and Kim, 1994). At risk groups such as refugees have rarely been interviewed in surveys of Asian-Americans, however (Zane and Sasao, 1992).

ASIAN-PACIFIC SUBSTANCE USE

Subgroups of Asians differ from each other in substantial ways. What is known about substance use in the larger, more established Asian groups such as the Chinese and Japanese may not apply to other, less established groups. Furthermore, general observations among other Asian groups may not apply to refugees. However, some factors relative to Asian groups as a whole can guide the discovery process as more is learned about Southeast Asians. For example, even when middle through high school student samples are included, Asians generally have fewer reported problems with alcohol and other drugs compared to other ethnic groups in the United States regardless of gender (Johnson et al., 1987; Maddahian et al., 1985, 1986; Sue and Morishima, 1982; Trimble et al., 1987).

Despite a large Asian population, for example, native Hawaiians and Caucasians have higher consumption rates for alcohol (Ahern, 1989; Murakami, 1989). Use of alcohol and other drugs appears to be increasing dramatically in student groups, however (Kim and Shantzis, 1989). Although reported prevalence is lower, the use of alcohol, cigarettes, cannabis, cocaine, and "hard drugs" is increasing among Asian youth (Maddahian et al., 1986).

The negative physiological response that some Asians have to alcohol, such as facial flushing and palpitations, has been given as one reason for decreased consumption (Newlin, 1989; Stoil, 1988; Wolff, 1973). Such information is subjective, however, since underreporting is believed to be the norm (Austin et al., 1989). It remains that the majority of reports on substance use by Asians focus on alcohol. Little is known about Southeast Asian groups relative to their patterns of alcohol or other drug use after entry into the United States.

Reports on Asians in general are conflicting. For example, it has been reported that substance use in Asians increases as they enter the American mainstream (Kim et al., 1992; NIAAA, 1990; Tsunoda et al., 1992). More acculturated Asian Pacifics (based upon language ability and generation in the United States) have reported greater alcohol consumption than their less accul-

turated counterparts (Sue et al., 1979). Does this reflect less inhibition to admitting use, the effects of acculturation, or both?

In the case of Japanese-Americans, their drinking consumption is reported to be similar to American drinking patterns, although social aspects of their drinking resemble styles in modern Japan (Kitano et al., 1985). There also may be "lag time" in either the resumption of substance use or decreased use after arrival in the United States, especially if use was associated with ceremonial or social activities in their country of origin. This change in usual substance-using habits often occurs during the initial period of months to years prior to the individual's assimilation into the culture. Krupinski (1967) first recognized that immigrants may not speak the language and may remain nonassimilated even after up to 15 years in their new countries. In the case of Hmong immigrants arriving before 1980, for example, an interruption of several months to 10 years occurred after their migration before opium use was resumed, while this gap narrowed to weeks to months for those arriving after 1985 (Westermeyer et al., 1991). Westermeyer (1985) also reported initial marked decreases in consumption of alcohol in the Hmong after arrival, which he attributed to altered social rituals.

Self-reported physiological reactions to alcohol, such as flushing, and attitudes toward drinking have sometimes accounted for greater ethnic differences than their cultural values did (Akutsu et al., 1989). In Asian communities at "high risk" for physical and emotional problems, such as San Francisco's Chinatown youth, prevalence of use and misuse of all substances appears similar to non-Asian samples, with women reporting greater use of codeine, Quaaludes, and Valium (Wong, 1985). This group may be more comparable to Southeast Asian "high risk" groups, since reported prevalence rates are higher than Chinese-Americans as a whole.

Sue et al. (1985) reported Chinese-American adults as having the lowest percentages of "heavy" drinkers and the highest percentage of abstainers when compared to other Asian groups as measured by the Quantity, Frequency, and Variability (QFV) Scale (Knupfer, 1966) where individuals are designated as abstainers, infrequent, "light," "moderate," and "heavy" drinkers. While drunkenness is frowned upon by the Chinese (Ahern, 1989; Chu, 1972), excessive drinking in the elderly is accepted because of alcohol's purported medicinal effects (Singer, 1972).

Prevalence rates for alcohol consumption by Japanese and Korean men appear similar to their American counterparts, but Japanese men and women are generally reported as having the highest rates of consumption (Chi et al., 1989). Greater acculturation and acceptance of social attitudes of peers seem to influence increased consumption of alcohol in both Chinese and Japanese college students (Sue et al., 1979).

SOUTHEAST ASIAN SUBSTANCE USE

There are very few studies that include Southeast Asians (Table 1). Of the three Southeast Asian groups, the Vietnamese and Hmong (Highland Laotians) have been best represented in research studies. Two studies of Vietnamese-Americans, for example, indicate variable substance use. In a study of 756 Vietnamese refugee adults in Texas, subjects admitted to using psychoactive substances as coping mechanisms to alleviate psychological distress: 44% smoked tobacco, 4% used alcohol, and 12% used other drugs (Yee and Thu, 1987). In another study of 496 Vietnamese subjects, 14% reported that they used alcohol or other drugs (Nicassio and Pate, 1984). Reported smoking rates in Southeast Asians in California are 71% for Cambodians, 92% for Laotians, and 55–65% for Vietnamese. These smoking rates are high compared with 30% for the United States population as a whole (DHHS, 1992).

A statewide Asian drug user service needs assessment was conducted in California to assess alcohol and other drug use (Saseo, 1991). Of the Southeast Asian groups, Vietnamese and Chinese-Vietnamese were included. The highest reported lifetime use of alcohol and other drugs was by Japanese (45%), followed by Filipinos (38%), Vietnamese (36%), Koreans (36%), Chinese (25%), and Chinese-Vietnamese (24%). Japanese also had the highest reported levels of alcohol consumption (69%), followed by Koreans (49%), Chinese (42%), Vietnamese (43%), Filipinos (39%), and Chinese-Vietnamese (39%). Eighty-six percent of the Vietnamese, and 81% of the Chinese-Vietnamese respondents said their drinking was socially stimulated.

The increasing use of alcohol among the Highland Laotians (Hmong) in the United States for self-treatment of insomnia, pain, and emotional stress also has been reported, as well as opium addiction. Out of 100 admissions for opium addiction at the University of Minnesota Hospital and Clinic 1985–88, most were Hmong, but there were also two Laotians (Lowland Laos), two Vietnamese, and two Tai Dam (ethnic minority from Laos). The majority of the addicts were male: 38 males to 15 females. Eighteen of the 100 individuals said they had begun opium use in the United States at the instigation of relatives (Westermeyer et al., 1989). A later study reported on a group of 49 Hmong and one Laotian opium addict seeking treatment for their addiction. The male–female addiction ratio remained more than double: 35 men to 15 women. Thirty-five out of the 50 smoked cigarettes and 13 consumed alcohol. Young addicts were generally uneducated, unemployed, and welfare recipients (Westermeyer et al., 1991). Opium was used for both physical and psychological symptoms. Thirty-eight out of the 50 subjects said they used alcohol and other drugs specifically to relax or enjoy life.

Table 1.

Southeast Asian Substance Use in the United States: Selected Studies

Authors	Location	Ethnic group	*N*	Sex
1. D'Avanzo et al. (1994)	Lowell, MA	Cambodian	60	Female
	Los Angeles, CA	Cambodian	60	Female

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
		Lowell, MA		
51.7%	Alcohol	Social/self	Present	Nonrandom sample
1.7%	"	Weekly/self		
3.3%	"	Daily/self		
11.7%	Street drugs	Social/family member		
1.7%	"	Weekly/family member		
1.7%	"	>2× daily/ family member		
		Los Angeles, CA		
15.0%	Alcohol	Social/self	Present	Nonrandom sample
1.7%	"	Weekly/self		
1.7%	"	>Daily/self		
1.7%	Street drugs	Daily/family member		
		Lowell, MA		
0.0%	Prescription drugs	Used for illness other than prescribed for/self		
3.3%	"	Used for street drug effects to forget troubles/self		
16.7%	"	Used as prescribed and for street drug effects/self		

(*continued*)

Table 1. *Continued*

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
0.0%	"	Used for illness other than prescribed for/family member		
3.3%	"	Used for street drug effects/family member		
5.0%	"	Used as prescribed and for street drug effects/family member		
		Los Angeles, CA		
58.3%	Prescription drugs	Used for illness other than prescribed for/self		
1.7%	"	Used for street drug effects to forget troubles/self		
6.7%	"	Used as prescribed and for street drug effects/self		
8.3%	"	Used for illness other than prescribed for/family member		
1.7%	"	Used for street drug effects/family member		
3.3%	"	Used as prescribed and for street drug effects/family member		

Authors	Location	Ethnic group	*N*	Sex
2. Morgan et al. (1984)	San Diego, CA	Caucasian	67	41 Male 26 female
		Black	65	24 male 41 female
		Hispanic	111	54 male 57 female
		Indochinese	69	62 male 7 female

Table 1. *Continued*

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
Indochinese males 66.1%	Alcohol	Drink alcohol	Present	San Diego Job Corps sample—low SES, low income
Indochinese females 42.9%	"			

Authors	Location	Ethnic group	*N*	Sex
3. Nicassio and Pate (1984)	Illinois	Cambodian 8.5% Laotians 21.1% Hmong 18.8% Vietnamese 51.3%	968	Male 79.6% Female 20.4%

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
85.8%	Alcohol/ drugs	Use not considered serious	Present	Nonrandom (mail survey, ESL classes, interviews)
7.8%	"	Use considered somewhat serious		
6.4%	"	Use considered very serious		

Authors	Location	Ethnic group	*N*	Sex
4. Saseo (1991)	California	Chinese	409	
		Japanese	416	
		Korean	399	
		Filipino	149	
		Vietnamese	322	
		Chinese Vietnamese	78	

Estimate use/ misuse	Drug type	Estimate	Drug type	Time interval	Study limitations
24.9%	Cig/tobacco	41.8%	Alcohol	Lifetime	Telephone survey
45.4%	"	68.8%	"		

(*continued*)

Table 1. *Continued*

Estimate use/ misuse	Drug type	Estimate	Drug type	Time interval	Study limitations
36.1%	"	48.6%	"		
38%	"	39.3%	"		
36.3%	"	43.2%	"		
24.4%	"	38.5%	"		
		85%	"	Last month	
		92%	"		
		77%	"		
		90%	"		
		86%	"		
		81%	"		

Authors	Location	Ethnic group	*N*	Sex
5. Westermeyer et al. (1989)	Minneapolis, MN	Hmong	55	38 Males 15 Females

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
59 patients	Opium	Opium smokers	Lifetime	Small sample
1 patient (2–3 doses daily)	Opium	Opium eater		
42 patients	Tobacco	31 daily smokers		
15 patients	Alcohol	Occasional use		

Authors	Location	Ethnic group	*N*	Sex
6. Westermeyer et al. (1991)	Minneapolis, MN	Hmong Laotians	49 1	35 Males 15 Females

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
50 patients (2–3 doses daily)	Opium	Opium smokers (also ate while traveling)	Lifetime	Small sample
35 patients	Tobacco	29 daily smokers		
13 patients	Alcohol	1 daily drinker		

Table 1. *Continued*

Authors	Location	Ethnic group	*N*	Sex
7. Yee and Thu (1987)	Texas Louisiana	Vietnamese 90% Hmong 10% Laotians Chinese Cambodian Ethiopian Polish Afghan	840	59% Male 41% Female

Estimate use/ misuse	Drug type	Definition	Time interval	Study limitations
45%	Alcohol/smoking	"Sometimes"	Present	Convenience sample
7.9%	"	"All the time"		
13.9%	Other drugs	"Sometimes"		
5.8%	Alcohol	"To diminish problems/sorrows"		
0.5%	Other drugs	"To diminish problems/sorrows"		
11.7%	Cigarettes	"To diminish problems/sorrows"		

The return to opium use, and the instigation of others to begin use, is consistent with the observation that immigrant groups tend to continue the substance use habits of their country of origin. After they have become more acculturated they frequently take on habits more similar to their new country (Liepman et al., 1993; Parrish et al., 1992).

The use of drugs and alcohol for either relief of physical pain or psychological problems appears to be common in the Southeast Asian community. In a study of Indochinese youth, 59% drank to forget the past and relieve depressive symptoms (Morgan et al., 1984). They also used a variety of other substances such as marijuana, speed, glue, paint, and angel dust, but their reported use was lower than other ethnic groups.

Use of alcohol by elderly Southeast Asians is well accepted by Laotians, Cambodians, and Vietnamese. Many traditional medicines are alcohol-based and are taken to give energy (gelatin from tiger bones dissolved in alcohol) or to relieve pain (opium in alcohol). In Cambodia the chewing of betel to produce a sense of euphoria is common and often continued in the United States.

THE GENDER GAP IN ASIAN-AMERICAN SUBSTANCE USE

The gender gap relative to alcohol consumption has been recognized for some time. This appears to be even greater in the Asian population, with Asian women having an even lower percentage of "heavy" drinkers than their male counterparts (Kim et al., 1992). Recent reports, however, indicate that consumption of alcohol and tranquilizers and the use of cigarettes are increasing in educated young and middle-aged Asian women (Chi et al., 1989; Kim et al., 1992; Towle, 1988). Heath (1993) states that the major differences between male versus female drinking has to do with the fact that men drink in larger quantities and become intoxicated more often, not that women's drinking is merely "token sipping" (p. 102). Even moderate consumption by women is significant due to alcohol's potential to cause fetal damage, and since it is known that women do not need to consume as much alcohol as men in order to experience serious health-related consequences. Concern that the United States has been experiencing an "epidemic" of women's drinking has caused more attention to be focused on these issues (Blume, 1991; Engs, 1990; Wilsnack and Beckman, 1984).

The gender gap takes on even greater significance in the present discussion if one recognizes that refugees are a high risk group, and that 80% of the world's refugee population is made up of women and children (Martin, 1991). High levels of emotional disturbance in women as a result of migration and adjustment to a new country have been recognized for some time (Krupinski, 1967). In recent studies of Cambodian refugee women in the United States (D'Avanzo, 1994; D'Avanzo et al., 1994), 52% of the respondents sampled on the East Coast said that they used alcohol socially and as an emotional block. About 45% of the 52% reported that alcohol was used for nervous complaints, headaches, insomnia, and pain, with vodka as the spirit of choice. Alcohol also was used traditionally, boiled with a variety of herbs obtained from Cambodia and Thailand, for a period of time following childbirth to "cleanse the blood." This practice was often insisted upon by their mothers or mother-in-laws, even when the women objected.

In addition, 15% of the East Coast respondents said that either a husband or adolescent child was having problems associated with substance use. The women expressed fears that adolescents were increasingly experimenting with drugs as they shed traditional Cambodian values. Such fears may be more than intuitive. Studies which have included Asian Pacifics, although not specifically Cambodians, have documented that the average use of nonalcoholic drugs for Asian-Pacific junior and senior high school students is comparable to Whites and Hispanics. Use of marijuana was 23%; over-the-counter drugs such as air fresheners, cough medicines, glue, and solvents 31%; barbiturates, amphet-

amines, and tranquilizers 20%; and cocaine, heroin, and hallucinogens 12%. Although there were few Asian-Pacific students who were classified as "heavy" drinkers, those that were consumed more alcohol than other ethnic groups (Weltie and Barnes, 1985). Prescription drugs appeared to be used more often than alcohol. These drugs were used for reasons other than that targeted by the prescriptions they received in over 58% of the West Coast group with "forgetting their troubles" a frequent reason in both West and East Coast groups. Subjects admitted to taking drugs for "street drug effects" on occasion, and it was commonplace for them to take sleeping pills to alleviate stress during daylight as well as evening hours. This was considered culturally acceptable as a way to reestablish equilibrium and harmony while not being a burden to others. The loss of traditions, poverty, unstable urban environments, role changes, cultural conflict, and situational "high risk" factors put these women at increased risk for inappropriate use of substances.

BARRIERS TO INTERVENTION FOR SOUTHEAST ASIANS

There are significant barriers to seeking treatment for substance use and misuse. Feelings of shame and stigma, described as "loss of face," are powerful deterrents to admission of chemical dependency. Feelings that the family, as well as the individual, will be stigmatized encourages silence about the problem so that status in the community will not be lost. Cultural customs regarding respect may prevent wives from confronting husbands or sons from confronting parents or grandparents about their misuse of substances. A "double standard" also exists in Asian cultures in that it is far more shameful for a woman to misuse substances than for a man to do so (Community University Health Care Center, 1987). Therefore, while men may seek stress relief in alcohol, as an alternative women try to forget or ignore stress so that they won't be a burden to others. One of the ways that may be accomplished is by misuse of sleeping pills or prescription drugs (D'Avanzo, 1994; D'Avanzo et al., 1994).

Religious values are a source of comfort in Southeast Asia. Monks often intervene in family difficulties, and the pagoda is a place of meditation and solace. This source of spiritual help has largely been lost in the United States, although many Southeast Asians maintain their Buddhist roots while attempting to embrace the Christianity of their sponsors. Although not admitted to directly, the Eastern concept of "Karma" frequently acts as a barrier to seeking treatment. The belief in determinism or "Karma" is held by many adult and in varying degrees by younger Southeast Asians. Suffering, in this view, takes on a spiritual dimension, and the meaning of suffering is believed to be beyond the individual's understanding (Community University Health Care Cen-

ter, 1987). Therefore, family disruption caused by substance misuse may be perceived as "Karma" rather than a problem to be solved. This results in an attitude of apathy, indifference, or acceptance (Te, 1988; Whitmore, 1979).

Intervention services, even when available, may not be considered as an option. It is known that Southeast Asians, as well as Asians in general, underuse substance user and mental health services (Zane and Kim, 1994). This has been perceived as a lack of need for services by these groups when in reality there is a critical shortage of culturally-appropriate substance user treatment and intervention programs (Zane and Kim, 1994).

Outcomes for Southeast Asians who attend intervention programs are also basically unknown. It has been reported that Asian-Pacific clients tend to stay in programs longer yet have high rates of continuing their drug use, perhaps because they delay in seeking treatment until they are in serious trouble (Phin and Phillips, 1978).

CULTURALLY-APPROPRIATE PREVENTION AND INTERVENTION

Culture-based factors that discourage or control substance use in the majority of Southeast Asians should be evaluated in light of improving intervention strategies (Zane and Kim, 1994). Yee and Thu (1987), for example, reported decreased use of alcohol and drugs in Asians living in more traditional extended family structures. The family unit and the ethnic community is a source of strength to the Southeast Asian, and where most problems are resolved. A family-oriented approach in which the extended family is included in issues of prevention, intervention, and treatment will, in most cases, have the best chance of success in the Southeast Asian community. Inclusion of the family is of particular importance since denial and underreporting of substance use, and resistance to getting outside help, is common in this community.

Nicassio and Pate (1984) also have stressed the importance of preserving the Southeast Asian family unit as a hedge against substance use. They noted the necessity of promoting the development of ethnic enclaves in both urban and rural areas because of the supportive functions that the ethnic community can provide. Culturally-appropriate strategies for prevention, such as religious or community involvement, may provide alternative ways to cope with stress. Achieving educational and job-related skills will help to reduce stressors such as poverty and low self-esteem that may contribute to being at "high risk" for substance abuse. The traditional norms of maintenance of balance and equilibrium discourage the use of substances which disrupt harmony, and these concepts also may be built upon.

It should be recognized that Southeast Asians may present with somatic symptoms such as insomnia or avoidance of work, and only when trust is established may they admit to substance-use-related problems. Because communication in Asian cultures is less direct than in Western culture, they may initially approach the problem indirectly by discussing "a friend's" misuse problems. They also may be reluctant to divulge their problems to opposite sex interviewers, since this may increase their sense of "loss of face." Individuals with poor English skills may not be willing to disclose problems to a Southeast Asian translator because they fear confidentiality may be broken.

Intervention and treatment programs should be multicultural and multilingual, and take into consideration the traumatic histories of Southeast Asian clients. Perceptions of proper respect and deference may dictate that the "expert" is expected to solve the problem with little input from the person misusing substances or their families. This can create conflict and frustration between client and interviewer if not understood and dealt with (Community University Health Care Center, 1987). When interventions are sensitive to cultural issues, however, treatment utilization rates are known to increase dramatically (Zane, 1989).

By the year 2000 the third largest minority group in the United States will be Asian Pacifics, with over a million Southeast Asians (US Bureau of the Census, 1990). Recent immigration and refugee groups are the fastest growing segment of the Asian-Pacific population. There is a need for research which will delineate to what degree they are "at-risk" for substance-misuse-associated problems (Zane and Kim, 1994) so that effective prevention and intervention programs may be developed. If current trends continue, substance use and misuse may emerge as a significant problem in this population.

RESOURCES

Asian American Psychological Association (AAPA)
Slippery Rock University of Pennsylvania
Slippery Rock, PA 16057, USA

Asian Pacific Resource Center
Montebello Regional Library
1550 W. Beverly Blvd.
Montebello, CA 90640, USA

Community University Health Care Center
University of Minnesota Hospital
2001 Bloomington Ave. So.
Minneapolis, MN 55404, USA

National Asian Pacific American Families Against Substance Abuse
1887 Maplegate St.
Monterey Park, CA 91755-6536, USA

Office of Minority Health Resource Center
P.O. Box 37337
Washington, DC 20013-7337, USA

Southeast Asian Family Empowerment Project
254 Adams St.
Dorchester, MA 02122, USA

Audiovisuals

Universal Health Associates Inc.
1701 K. St., NW, Suite 600
Washington, DC 20006, USA

Curriculums

Burns, C., and D'Avanzo, C. (1993). Nursing Education Curriculum "Alcohol & Other Drug Abuse in Culturally Diverse Populations: Hispanics and Southeast Asians." Available from Dr. C. D'Avanzo, 135 Grier Road, Vernon, CT 06066, USA

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Ethnic Differences in Substance Use and Alcohol-Use-Related Mortality among First Generation Migrants to England and Wales

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ABSTRACT

Epidemiological studies among migrant ethnic groups are potentially important as a way to provide insight into the relative importance of genetic, cultural, and socioeconomic factors in the etiology of substance use disorders. This paper summarizes prior United Kingdom studies of the prevalence of substance-use-associated problems in different ethnic groups before analyzing trends in recent mortality data by country of birth. On this evidence, rates of alcohol-related mortality may be marginally higher for those born in the Caribbean than for the native British, but are substantially raised for those born in Ireland and the Indian subcontinent. There is some indication that rates for the Caribbean and possibly the Irish groups have risen more rapidly than for the national population over a 12-year period. These differences in mortality rates seem to have arisen for complex reasons. [Translations are provided in the International Abstracts Section of this issue.]

Key words: Ethnicity; Alcohol-related mortality; England and Wales

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INTRODUCTION

Rates of substance-use-associated problems are known to vary widely by ethnic group, and epidemiological studies among migrant ethnic groups are potentially an important way to provide insight into the relative importance of genetic, cultural, and socioeconomic factors in the etiology of substance use disorders. Yet despite long-standing stereotypes around ethnic drug use, there has been little research into the nature, range, and extent of substance-use-associated problems among ethnic minority populations in Britain. Much of the available evidence on ethnic differences in the use of psychoactive substances is derived from routinely collected official statistics. Most official statistics in the United Kingdom (UK) are collated separately for England and Wales, Scotland, and Northern Ireland, and of these countries only England and Wales have sizable ethnic minority populations. The 1991 UK Census, which was the first to include a question on ethnic origin, showed that the visibly different ethnic minorities (those of African, Asian, or Chinese origin) constituted nearly 3 million, or 5.8%, of the total population of 49,890,277 in England and Wales (Office of Population Censuses and Surveys, 1993).

In this paper, evidence on the prevalence of illicit drug and alcohol-use-related problems among different ethnic groups in England and Wales is summarized before recent data on alcohol-related mortality by country of birth are analyzed and trends in mortality over the last 12 years examined. Trends in mortality could help clarify which factors make for "vulnerability" or "resilience" among ethnic groups. If, for example, high problem rates among migrant ethnic groups are linked to short-term migration stress or culture shock (Furnham and Bochner, 1986), the trend in mortality should be downward, given that large-scale primary immigration into England and Wales effectively ceased in 1971. If mortality is increasing for some groups, it could reflect specific environmental stresses or difficulties in acculturation.

ETHNIC VARIATIONS IN THE PREVALENCE OF ILLICIT DRUG PROBLEMS

Evidence on ethnic variations in rates of illicit drug-use-associated problems in England and Wales is extremely limited. Until recently, when a general population survey of people's experience of crime was adapted to include questions about illicit drug use (Ramsay and Percy, 1996), there were no regular national surveys recording patterns of illicit drug use as there are for drinking, and the annual number of drug-related deaths in England and Wales (typically less than 400) is too small to permit meaningful statistical analysis in terms of ethnicity.

There are three sets of routinely collected statistics that provide some information relating to ethnic drug use. First, until 1982 English hospital activity statistics recorded patients' country of birth, and analyses of psychiatric hospital admission rates for immigrants have been produced for 1971 (Cochrane, 1977) and 1981 (Cochrane and Bal, 1989). Second, annual statistics are available from 1990 for individual English health regions on the utilization of drug user treatment agencies by ethnicity. Third, there are occasional national statistics on the ethnic origins of those imprisoned for drug-related offences (Home Office, 1994).

Cochrane and Bal (1989) analyzed English National Health Service psychiatric hospital admission rates for 1981 by country of birth. They found that admissions for drug misuse were highest for men born in Scotland, Northern Ireland, and Italy, with a rate of admission over three times greater than the native English (17 per 100,000 population compared to 5). There were also high admission rates for men born in Southern Ireland and the Caribbean (13) and in Hong Kong (12). Admission rates were generally lower for women, but were relatively high for those from Northern and Southern Ireland and from Kenya (8 per 100,000 population compared to 3 for English women). The rate for Indian women was low (2), and rates were negligible for women from the Caribbean, Pakistan, and Hong Kong.

The statistical returns on the utilization of drug-user treatment agencies, available through the Regional Drug Misuse Databases in England, record relatively few ethnic minority people seeking help: in the case of the Northern and Yorkshire region, only 3% of all clients are recorded as being from a minority ethnic group in 1993, although as previously noted non-White ethnic minorities comprise 5.8% of the population of England and Wales (Yorkshire Substance Misuse Information Centre, 1993:29; Office of Population Censuses and Surveys, 1993). In those Yorkshire districts where the minority ethnic population is above 15%, minorities still represent less than 8% of those using the services of drug- and alcohol-user treatment agencies.

The low rates of attendance at treatment agencies are in marked contrast with the relatively high rates of hospital admissions for drug misuse found for Black people in 1981 (Cochrane and Bal, 1989). Cochrane and Bal's 1981 findings may reflect the greater use of compulsory hospital admissions for young Black men combined with the controversial use of the diagnosis "cannabis psychosis" (See Note 1) (Gruber and Pope, 1994; Mathers and Ghodse, 1992; McGuire et al., 1994), a diagnosis that has been given almost exclusively to Black people in England (McGovern and Cope, 1987).

In the absence of more detailed investigation it is hard to say whether the apparent underrepresentation of ethnic minority people in treatment agency caseloads reflects a lower prevalence of drug-use-associated problems, the lack

of ethnically sensitive services, or a divergence in help-seeking behavior. To some extent, the apparent underrepresentation of ethnic minority people may even be an artifact of underreporting, since many agencies code ethnicity as "unknown" in their statistical returns (Yorkshire Substance Misuse Information Centre, 1993:29). Even if the extent of agency underreporting could be reduced, these data would still be of limited use as they are restricted to clinical populations, and there are no reliable UK estimates of the extent of drug use in nontreatment-seeking ethnic minority populations, or of the ratio of known to unknown users among different minorities.

Some studies have suggested that Black people are less likely to be opiate users, the principal group seen by the drug-user treatment agencies, and more likely to use other substances like cannabis (Mirza et al., 1991). Most arrests of Black people for drug offences are for the possession of cannabis, and police "stop and search" tactics aimed at the possession of cannabis by Black youths have been mentioned in several reports on inner city disturbances as a source of conflict between the police and the Black community (see, for example, Scarman, 1981). However, the 1994 British Crime Survey, a national self-report study with a 95.6% response rate ($N = 11,167$), indicates that while heroin use is lower among African-Caribbeans than Whites, it is higher among Pakistanis and Bangladeshis (Ramsay and Percy, 1996). Overall, White and African-Caribbean people in England and Wales seem to have broadly similar patterns of drug use, but when the age group 16–29 is considered, White youths have a substantially higher level of illicit drug use than African-Caribbeans or any other group (Ramsay and Percy, 1996).

This is in marked contrast to rates of imprisonment for drug-associated offences. British prison statistics do not record ethnicity on a routine basis, but in 1994 the British government published a report on the ethnic origins of prisoners in England and Wales in 1990. This shows that Black African and African-Caribbean men were three times more likely to be imprisoned for drug-associated offences than White men (Home Office, 1994:Table 7). Black women under 21 years were four times more more likely, and those over 21 three times more likely, to be imprisoned for drug-associated offences than White women. Indeed, Black women represented 30% of all women receiving custodial sentences in England and Wales in 1991, although they constituted less than 1.8% of the female population (Barclay et al., 1995; Office of Population Censuses and Surveys, 1993:Table 7). This was partly due to the large number of Black women who were non-UK nationals and were convicted of drug smuggling offences (the so-called "mules" who carry illicit drugs through customs).

On this evidence, there is little difference in patterns of drug use, but Black people appear to be underrepresented in the drug-user treatment statis-

tics and overrepresented in the penal statistics. This has been found in other areas of mental health practice in Britain, and appears to be related to institutional racism in the health and criminal justice systems (Littlewood and Lipsedge, 1982). Thus the higher proportion of Black men and women imprisoned for drug-associated offenses seems to reflect police enforcement priorities and sentencing bias (Hudson, 1989) rather than differences in offending behavior.

ETHNIC VARIATIONS IN THE PREVALENCE OF ALCOHOL-RELATED PROBLEMS

There is rather more evidence on ethnic variations in rates of alcohol consumption and related problems. A consistent finding from UK studies of alcohol consumption is that African-Caribbean men and women, and men and women born in the Indian subcontinent (South Asians), report substantially lower levels of drinking than the native British, whereas men born in Ireland report levels that are considerably higher (Balarajan and Yuen, 1986; Blakemore, 1984; Cochrane and Howell, 1995; Cruikshank et al., 1985; Donaldson, 1986; Haines et al., 1987; Harrison et al., 1993; McKeigue and Karmi, 1993).

Harrison et al. (1993) analyzed self-reported drinking rates in the 1988 General Household Survey, a nationally representative annual study of 10,000 British households which includes occasional questions on alcohol consumption (OPCS, 1990). The number of first generation migrants from the Irish Republic in a total sample of 16,855 was 227; second generation, 442. The number of first generation migrants from Northern Ireland was 111; second generation, 168. Drinking rates were represented by indices where overall GHS drinking rates equaled 100. When adjusted for age and gender, the rate of high "risk" drinking (see Note 2) among first generation Irish migrants was 173, and for second generation migrants 123. The rate among first generation migrants from Northern Ireland was 122, but it was even higher for second generation migrants at 178.

These high levels of consumption are accompanied by extremely high rates of psychiatric hospital admissions for alcohol-use-related diagnoses, whether first admissions or all admissions are considered (Cochrane and Bal, 1989). In some districts, psychiatric admissions are over five times higher for Irish than for British-born men (Mather and Marjot, 1989). Little is known about the drinking patterns of Irish women after migration to England (Harrison and Carr-Hill, 1992), but once resident they appear to have very high admission rates to psychiatric hospitals. In 1981 the rate of admission for all psychiatric diagnoses was double that for women born in England, while the rate for alcohol-related diagnoses was seven times greater (Cochrane and Bal, 1989:Table 5).

Balarajan and Yuen (1986) analyzed drinking rates in the 1978 and 1980 General Household Survey by country of birth (total sample 23,514 households and 21,764 men over 18 years). When standardized for age and socioeconomic status in Great Britain, they found male drinking ratios of 103 for men born in England but of 52 for men from the Caribbean men and only 45 for men born in the Indian subcontinent, indicating much lower consumption levels than the UK national average. These findings are consistent with unpublished data from several surveys of blood pressure and cardiovascular risk factors (reviewed in McKeigue and Karmi, 1993).

The lower levels of at-risk drinking reported among African-Caribbean migrants to the UK have been paralleled by lower rates of hospital admissions for alcohol-use-related diagnoses. The Caribbean admission rate of 27 per 100,000 population in 1981 was considerably less than the rate of 38 found for men born in England (Cochrane and Bal, 1989). However, there are some indications that the picture has changed since the original studies by Cochrane (1977) and by Taylor et al. (1986). Cochrane and Bal (1989) found an upward trend in alcohol-related admissions between 1971 and 1981, with the highest increase (121%) among men born in India. Admissions for Caribbean-born men had increased by about 75% over this 10-year period, in line with the increase for men born in England.

The lower levels of alcohol consumption reported by men and women born in the Indian subcontinent contrast with high rates of male hospital admissions for alcohol-use-related diagnoses for some ethnic groups (Banerjee and Virdee, 1986; Cochrane, 1977; Mather and Marjot, 1989). Men born in India had a psychiatric hospital admission rate of 73 per 100,000 population in 1981, compared to 38 for men born in England (Cochrane and Bal, 1989). The discrepancy between high hospital admission rates and low reported alcohol consumption for this group may be due to the unreliability of self-report data. People vary in their willingness to disclose drinking habits, with "heavier" drinkers tending to underreport (Kreitman, 1977). For this reason, most self-report surveys of general populations in the UK account for only a proportion of the alcohol known to be consumed from other sources. The 1978 UK Office of Population Censuses and Surveys' study of drinking behavior, for example, accounted for only 60% of the alcohol reported sold by Customs and Excise (Wilson, 1980).

It is possible that the self-reported alcohol consumption levels for South Asians are reasonably accurate, however. There is no fixed relationship between levels of consumption and levels of alcohol-use-related harm that holds across communities. Mean alcohol consumption and rates of cirrhosis are poorly correlated between regions in the same country (Crawford et al., 1985),

and it is also possible that there are variations in "vulnerability" by age, class, and ethnicity (Cahalan and Room, 1974).

Moreover, there are considerable ethnic differences among migrants to Britain from the Indian subcontinent, and drinking patterns for these different groups need to be disaggregated wherever possible. Cochrane and Bal (1990) conducted a random community survey of 800 Sikh, Hindu, Muslim, and White men in the West Midlands. Sikhs were most likely to be regular drinkers, followed by Whites and Hindus. Among both Sikhs and Hindus, alcohol consumption was heaviest among older men, reversing the usual inverse relationship between age and alcohol consumption levels. Alcohol-related problems were positively associated with consumption levels for all groups, but the very few Muslim men who drank alcohol consumed the most on average and had the highest rates of problems.

The general picture gleaned from studies of ethnic variations in alcohol-related morbidity is borne out by mortality data. Most studies indicate that deaths from alcohol-use-related diseases such as cirrhosis of the liver are below average for men and women born in the Caribbean, but are elevated among Irish men and women and South Asian men (Balarajan et al., 1984; Britton, 1990). Thus, in the early 1980s, Caribbean-born men under the age of 70 had Standardised Mortality Ratios (SMRs) (see Note 3) for chronic liver disease and cirrhosis of 91. The SMR for Caribbean-born women was 52. Irish men and women, on the other hand, had SMRs of 204 and 180 respectively. South Asian men had even higher SMRs at 255, but the cirrhosis mortality rate for South Asian women (SMR 81) was lower than expected (Britton, 1990:199). An earlier (1984) study by Marmot and colleagues, based on data from 1970–1972 and from 1970–1978, found high cirrhosis SMRs not only for the Irish and South Asians but also for Caribbean-born men (142) and women (205).

The findings for South Asian men and women were confirmed by Balarajan and colleagues (1984). They used the names from all death certificates in England and Wales between 1975–1977 to identify the regions or ethnic groups in the Indian subcontinent from which 2,623 deceased men and 1,034 women may have originated. Cirrhosis mortality was particularly raised for Punjabis and Gujeratis, with proportional mortality ratios of 282 and 213 respectively, but it was also elevated for Moslems (161).

The data in Balarajan et al.'s (1984) study are derived from death certificates for 1975–1977, however, while the most recently published UK data on alcohol-related mortality by country of birth dates from 1979–1983 (OPCS, 1990). One of the most important studies of ethnic mortality is based in part on data from 1970–72 (Marmot et al., 1984); these data are now over 25 years old. In view of Cochrane and Bal's (1989) finding that alcohol-related morbid-

ity seems to be increasing at a faster rate among some ethnic groups that others, it cannot be assumed that the picture has remained unchanged since the 1970s. The present study was undertaken to update earlier estimates and provide an indication of the trend in alcohol-related problems over recent years.

METHODS

Data on causes of death by country of birth were obtained for England and Wales from the UK's Office of Population Censuses and Surveys for the most recent years available, 1979–1991. The countries included in this study were grouped together as the Indian subcontinent (Bangladesh, India, and Pakistan), the Irish Republic, and the Caribbean Commonwealth (Belize, Barbados, Guyana, Jamaica, Trinidad, and the other former British West Indian islands). Not included were places that have relatively small numbers of migrants to England, such as Africa and the Far East, and ethnic groups which cannot be readily identified by country of birth, such as East African Asians. Country of birth does not correspond directly to ethnicity, as over 53% of Britain's Black population were born in the UK (Office of Population Censuses and Surveys, 1993), and a small but diminishing number of Whites were born in former British colonies like India. Nevertheless, country of birth identifies the first generation of immigrants fairly accurately, and provides the only reliable data which can be used currently to estimate variations in mortality by ethnic group.

The data obtained relate to selected causes of death known to be associated with alcohol. The selected causes were those International Classification of Disease (ICD-9) categories known to be directly caused by alcohol consumption: ICD 291, alcoholic psychosis; ICD 303, alcohol dependence syndrome; ICD 357.5, alcoholic polyneuropathy; ICD 425.5, alcoholic cardiomyopathy; ICD 535.3, alcohol gastritis; ICD 305, nondependent abuse of alcohol; ICD 790.3, alcohol poisoning. Those diagnostic categories where alcohol accounts for less than 100% of deaths, such as neoplasm of the larynx, were also obtained but were not used in this analysis since it was not possible to determine whether and to what extent the proportion of deaths attributable to alcohol varied by ethnic group. The exception was chronic liver disease and cirrhosis (ICD 571), where an alcohol attributable fraction of 80% was employed (Schmidt, 1977): thus the values used in this study are 80% of total reported cirrhosis mortality for each ethnic group. This could introduce a degree of error depending on the extent of ethnic variation in the proportion of cirrhosis deaths attributable to alcohol, but this approach was judged preferable to the use of the whole ICD 571 category without correction, or to the use of those subcategories of 571 which have a specific mention of alcohol (ICD-

571.0–571.3), because of evidence of substantial underreporting of specified alcoholic cirrhosis (Haberman and Weinbaum, 1990).

The data on alcohol-related causes of death were aggregated and SMRs for All Alcohol-Related Mortality were calculated for each year between 1979 and 1991 using census data on the age and sex structure of each population. Because there was a marked shift in the age structure of the Caribbean group between the 1981 and 1991 censuses, the population figures for each year between 1979 and 1991 were estimated by linear extrapolation for each combination of place of birth, age, and sex group in order to avoid distortions arising from the use of outdated population figures.

Three-year rolling averages of these SMRs were calculated. The effect of calculating rolling averages is to smooth out random fluctuation in the annual SMRs. From these rolling average plots (presented in Fig. 2 below) it seems reasonable to assume that the true SMR was approximately constant over a 3- or 4-year period for each place of birth group. Therefore, data from the years 1989–1991 and 1979–1982 were aggregated to calculate new SMRs for these three groups and provide more precise estimates of the true SMRs in these periods.

For each group, 95% confidence intervals were calculated for the true SMRs. These confidence intervals are simultaneous, i.e., the probability that all three intervals contain the relevant true values is at least 0.95. The confidence interval calculations used the approach described by Clayton and Hills (1993:148). It was assumed that for each place of birth group the mortality rates follow a proportional hazards model. That is, the ratio of the true mortality rate for a given age, sex, and place of birth group to the national mortality rate for that age and sex group was assumed to be constant. At the time of writing there are insufficient data to check this assumption.

Finally, simultaneous 95% confidence intervals for the ratio of the true SMR in 1989–1991 to that in 1979–1982 were calculated for each place of birth group. The method for these calculations was that used for the construction of a confidence interval for a ratio by Clayton and Hills (1993:Chapter 13). As before, this approach required the assumption that the data followed a proportional hazards model in both of these time periods. Additionally, it was necessary to assume that the random fluctuations during these two time periods were statistically independent.

RESULTS

Figure 1 shows the SMRs for each place of birth group for each year between 1974 and 1991. The trend appears to be upward for the Irish and

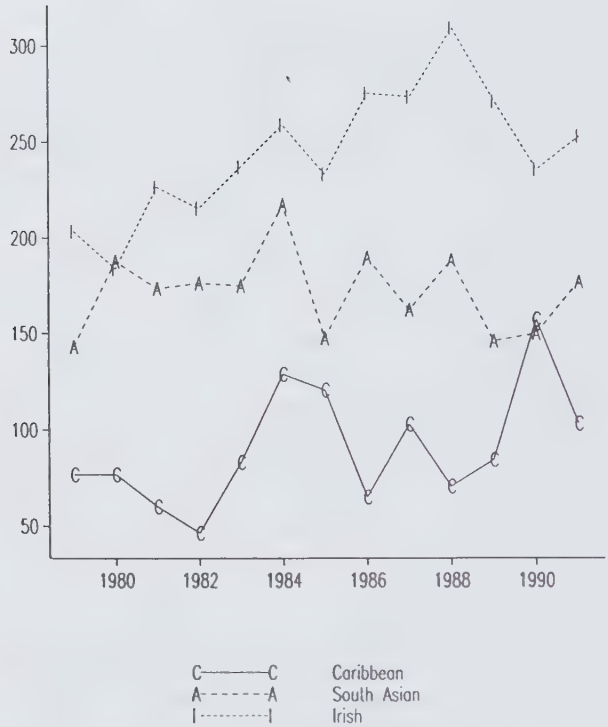

Fig. 1. Annual SMRs for each place of birth group, 1979–1991.

Caribbean groups, but there is a certain amount of random fluctuation, particularly for the Caribbean group, which has the smallest numbers of deaths.

Three-year rolling averages of the yearly SMRs are presented in Fig. 2. It can be seen that the Irish SMR has risen since 1980, possibly peaking in 1987/88. The SMR for the South Asian group appears to have remained fairly steady, while that for the Caribbean group has risen, although there is still considerable fluctuation.

Table 1 shows the number of deaths and SMRs for All Alcohol-Related Mortality by place of birth aggregated for the 3-year period 1989–1991, together with the 95% confidence intervals for each SMR. From the confidence intervals cited in Table 1 it appears that, currently, the Irish have markedly higher rates of alcohol-use-related mortality than the general population: the lower limit for the SMR is over twice that expected. Alcohol-use-related mortality for those born in the Indian subcontinent is also high: the lower limit for the SMR is over 130. The picture for the Caribbean group is less clear, as the confidence interval is rather wide.

Fig. 2. Three year rolling averages for SMRs for each place of birth group, 1980–1990.

Table 2 shows the confidence intervals for changes between 1979–1982 and 1989–1991. It is clear that the greatest observed increase arises for the Caribbean group: the current observed SMR is 1.768 times that in 1979–1982. Once again, however, the small number of deaths within this group means that

Table 1.

Standardised Mortality Ratios and Numbers of Deaths from All Alcohol-Use-Related Mortality[a] in Different Place of Birth Groups, 1989–1991

Group	*N*	SMR	CI
Caribbean	72	115.1	86.7, 152.7
South Asian	208	157.7	133.5, 186.3
Irish	372	252.1	222.6, 285.5

[a]ICD 291, 303, 357.5, 425.5, 535.3, 305, 790.3, 571, 572.3, 577, 161, 150, 140–149.

Table 2.

Confidence Intervals for Ratios of SMRs for Place of Birth Groups between 1979–1982 and 1989–1991

Group	Observed current SMR (CSMR)	Observed earlier SMR (ESMR)	CMSR/ ESMR ratio	95% CI for true SMR ratio
Caribbean	115.1	65.1	1.768	1.073, 2.913
South Asian	157.7	170.4	0.926	0.720, 1.189
Irish	252.1	207.3	1.206	1.008, 1.467

less precision can be attached to this figure. The Caribbean confidence interval is wide: the data are consistent with the true current SMR being either 1.1 or 2.9 times the true earlier SMR.

For the Irish, alcohol-use-related mortality has been consistently high. There is some evidence that the situation has worsened slightly since the 1970s. At best the true Irish SMR has remained the same; at worst it could have increased by 46.7%.

For the South Asian group, there is also considerable excess alcohol-use-related mortality, but the trend appears in line with the increase for the national population. There is little evidence that the mortality rate relative to that of the national population has changed.

DISCUSSION

During the 1970s, rates of death from alcohol-use-related diseases among the first generation of migrants from the Caribbean were lower than among the national population. Caribbean all-cause mortality was also lower than expected (Britton, 1990). The present study shows that alcohol-use-related mortality appears to have increased among Caribbean migrants over the last 12 years, however, and may now be elevated. Alcohol-use-related mortality has been consistently elevated for Irish and South Asian migrants. This is in line with the findings of prior studies (Balarajan et al., 1984; Britton, 1990; Marmot et al., 1984:4) and with all-cause mortality for these groups. All-cause mortality for Irish migrants is substantially higher than mortality in England and Wales or in Ireland, while South Asian mortality is marginally higher than for the national population (Marmot et al., 1984; Britton 1990).

There are a number of possible explanations for these findings. They could: reflect inaccuracies in recording the country of birth on death certificates, so that the observed differences are more apparent than real; or result

from selection bias, if those who migrate are already predisoposed to "heavy drinking" or are more "vulnerable" to alcohol-user-related harm. Alternatively, they could be inherited; be a response to the stress of migration, or reflect difficulties in acculturation; be related to the experience of discrimination and socioeconomic disadvantage; or be an interaction between two or more of these factors. Each of these possible explanations will be examined briefly before directions for future research are indicated.

Recording Error

A number of studies have called into question the accuracy of the information recorded on death certificates, both in general (Jordan and Bass, 1993) and in relation to specific disorders, like dementia (Morgan and Clarke, 1995) or alcohol-use-related diseases (Agren and Jakobsson, 1987; Bell and Cremona, 1987; Kemp and Carstairs, 1987; Perola et al., 1994). Could lack of accuracy in recording country of birth data on UK death certificates introduce a systematic bias, leading to the overestimation of ethnic mortality?

The evidence from North America suggests that any bias usually operates in the opposite direction, causing ethnic mortality to be underestimated. In the United States, Hahn and Eberhardt (1995) corrected for bias in population and mortality data and found that this substantially decreased life expectancy estimates for Native Americans and Asians. Others found that inaccuracies in recording ethnicity on death certificates had the effect of causing Black infant mortality to be underestimated (Farley et al., 1995). Similarly, mistakes in classifying causes of death have led to the underreporting of Black suicide rates (Phillips and Ruth, 1993).

A measure of the accuracy of death certification for England and Wales is available from the OPCS Longitudinal Study, which links census and death certificate information for a 1% sample of the population (Fox and Goldblatt, 1982). The country of birth recorded in the 1971 census was compared to that given in subsequent years on death certificates for the same individuals. Discrepancies were shown for around 5% of the Irish, 8% of South Asians, and 4% of the Caribbean Commonwealth (Marmot et al., 1984:Table 2.1). Errors of this magnitude are likely to have a fairly small effect on mortality ratios, and this effect is likely to be in the direction of underestimating ethnic mortality, as in North America.

A second possibility is that ethnic stereotyping is leading to misdiagnosis (Littlewood and Lipsedge, 1982). However, it is hard to believe that this could account for observed alcohol-use-related mortality for the Irish remaining over twice that expected over a 12-year period.

Confounding Variables

The second possibility is that a proportion of the observed mortality is due to causes other than alcohol, such as viral hepatitis. Twenty-five percent of the carriers of hepatitis B develop serious liver disease (Viral Hepatitis Prevention Board, 1996). Hepatitis B is endemic in the Indian subcontinent (Viral Hepatitis Prevention Board, 1996), and this could account for the high SMRs for chronic liver disease and cirrhosis among South Asian immigrants. Although the present study examined all alcohol-related mortality rather than just chronic liver disease and cirrhosis, the latter is the largest single cause of alcohol-use-related deaths. Our estimates of alcohol-use-related mortality are therefore sensitive to any change in the estimate of the proportion of cirrhosis deaths attributable to alcohol.

Approximately 50% of all chronic liver disease and cirrhosis (ICD 571) is identified as alcohol-use-related (ICD 571.0–571.3) in England and Wales; the present study followed Haberman and Weinbaum (1990) and Schmidt (1977) in estimating that 60% of unspecified liver disease is also alcohol-use-related. Such assumptions might be unsafe if some groups have higher levels of viral hepatitis infection or of parasitic disease of the liver, and future investigators might be advised to restrict their analysis to specified alcoholic liver disease.

If hepatitis was the sole cause of excess cirrhosis mortality among South Asians, however, it would be reasonable to expect deaths to be distributed evenly between the sexes; the excess cirrhosis mortality observed in two out of three prior studies was concentrated almost exclusively among South Asian men. In Britton's (1990) and in Balarajan and colleagues' (1984) studies, the South Asian women, who have very low reported alcohol consumption, also have low cirrhosis rates; in Marmot and colleagues' (1984) study, based on data from 1970–1972, female SMRs were raised (188). However, Marmot's analysis is based on a small number of cases (20) and the confidence intervals, although not stated, must be wide; also the proportional mortality ratio given for South Asian women in the same study, based on data from 1970–1978, is only 102, suggesting that the female SMRs reflect random fluctuation. The authors of the present study were not supplied with the separate male and female mortality data which would enable them to calculate female SMRs, but the probable concentration of cirrhosis mortality among South Asian men, together with high rates of male hospital admissions for alcohol-use-related diagnoses, strongly suggests that one of the principal causes of the raised cirrhosis mortality rates among South Asian men is excessive alcohol consumption.

This leaves the possibility that viral hepatitis is a cofactor in the pathogenesis of liver disease. In a study of 147 alcohol-dependent inpatients in an English hospital, men born in the Indian subcontinent were found to have significantly higher values for gamma glutamyl transpeptidase than White men with similar alcohol consumption levels, suggesting that South Asian men may be more vulnerable to alcohol-use-related liver damage than the indigenous White population (Clarke et al., 1990). Wickramasinghe and colleagues (1995), studying twenty-two South Asian men and thirty-two European men admitted to an English alcohol dependency unit for detoxification, also found that South Asian men were more "vulnerable" to alcohol-use-related liver damage and acetaldehyde-mediated hemoglobin modification than European men who had drank at similar high risks levels for a considerably longer period. There is some evidence that viral hepatitis confers "vulnerability" to liver disease in "heavy drinkers," and a distinct possibility, therefore, that men born in the Indian subcontinent who drink "heavily" might be at additional risk of liver disease because of chronic viral hepatitis (Adelasco et al., 1987; Coelho et al., 1995; Shiomi et al., 1992).

Prevalence in Country of Origin

In order to assess the significance of the high rates of alcohol-use-related mortality seen among Caribbean, South Asian, and Irish migrants, it is necessary to have some kind of baseline measure of problem prevalence in the countries of origin.

Data on the pattern and volume of alcohol consumption in the Caribbean Commonwealth are limited, and the likelihood is that each island differs considerably. The World Health Organization (1991) reported cirrhosis mortality rates per 100,000 population in the mid-1980s for some Caribbean islands: male rates for Jamaica (5.6) and Barbados (5.8) were lower than in England and Wales (6.5), while those for the Bahamas (22.7), St Lucia (14.2), and Trinidad and Tobago (16.3) were much higher. The pattern of mortality in the Caribbean is clearly diverse, and it is not possible on the basis of this evidence to generalize about the prevalence of drinking problems in the region.

There are also considerable regional variations in drinking practices in the Indian subcontinent. Moslem Pakistan and Bangladesh remain predominantly abstinent societies, while Indian drinking practices are more varied. While several Indian States prohibit alcohol, there has been a massive increase in alcohol consumption in others, like Punjab State. The rise in disposable incomes following agricultural improvements in the Punjab has been accompanied by greatly increased alcohol production: it has been estimated that in the 1980s the "average head of household in Punjab spent one thousand times

more on alcohol than on conveniences or improvements" (Mohan and Sharma, 1995:139).

Since Sikhs come mainly from the Punjab, and Moslems from Pakistan and Bangladesh, drinking practices within these ethnic groups in England (Balarajan et al., 1984; Cochrane and Bal, 1990) are not inconsistent with the little that is known about drinking practices in the region of origin.

Much more is known about drinking practices in Ireland. Per capita alcohol consumption in Ireland and the UK is similar, at around 9 liters of ethanol, but the pattern of drinking differs, with Ireland having one of the highest rates of beer consumption in the world and a pattern of episodic "heavy drinking" (Walsh, 1989). The distribution of consumption is also slightly different, with men living in Ireland being marginally more likely to be either lifelong abstainers or to drink at high risk levels than men in England (Harrison et al., 1993). Irish rates of cirrhosis and of self-reported drinking problems are broadly similar to those in England and Wales.

Cross-national comparisons are notoriously misleading, and it is difficult to compare Ireland, a largely rural country with a population of only 3.5 million in 1988, to England, a densely populated country of over 47 million. England is not only a much larger country, it has a wide variation in regional drinking patterns. Putting the differences between England and Ireland into context, Ireland's population is approximately the same as that of the former Yorkshire health region in England (3.5 million), and the rate of male high risk drinking in Ireland (9%) is close to that seen in English regions like Yorkshire and Humberside (8%), where men also drink more than the UK national average. Women in Ireland, on the other hand, drink more moderately than women in England and Wales; their rates are closer to those of women in low-drinking English regions like the West Midlands (for English regional rates see OPCS, 1990:143).

To summarize, none of the migrant groups studied here had uniformly low rates of alcohol-use-related problems in the country of origin, and it is possible that some Caribbean islands and some regions of the Indian subcontinent have rates that are rather high. The high levels of alcohol-use-related mortality found in the present study may reflect drinking practices that are common in the country of origin, therefore. The continuation of previously learned drinking behaviors is not a sufficient explanation, however, as most migrant groups end up with mortality rates that are midway between the country of origin and the country of adoption (Marmot et al., 1984). Higher mortality rates usually decline in subsequent generations; the consumption and problem rates for at least one migrant group in this study, the Irish, are even heavier in the second generation (O'Connor, 1978; Harrison et al., 1993; Greenslade et al., 1995).

There appear to be marked intergenerational continuities in Irish migrant drinking behaviors, although it is worth noting that a recent study by Mullen et al. (1996), in which religious affiliation and surnames were used to identify people of Irish descent living in the West of Scotland, found no statistically significant differences in drinking practices between the Irish and indigenous populations by the third and subsequent generations. The possibility that intergenerational continuities in alcohol-use-related problems within the Irish community result from some kind of inherited "vulnerability" is considered in the following section.

Inheritance

High rates of alcohol-use-related problems increase for the second generation of Irish migrants but seem to decline subsequently. This pattern is more likely to be due to cultural than genetic inheritance. While there is some evidence for genetically transmitted variations in the metabolic response to alcohol by ethnic group, this is largely related to the so-called "Oriental Flush," an increased alcohol sensitivity which is more common in people of Chinese and Japanese descent and which results from a deficiency in a high-activity form of the ALDH enzyme (Reed, 1985). This increased sensitivity is believed to confer a protective effect against the development of alcohol-use-related problems (Reed, 1985). There is no evidence, at present, that any genetically acquired mechanism which could confer "vulnerability" to the development of alcohol-use-related problems is linked to ethnicity.

Cultural differences have been a focus for attention since Bales' (1946) attempt to explain ethnic variations in rates of alcohol problems in terms of cultural orientations toward alcohol use. Bales has been criticized for oversimplifying cultural beliefs about drinking. Irish attitudes toward drunkenness were described as "convivial," for example, ignoring historical evidence that public discourse became contentious and highly politicized with the rise of the temperance movement in nineteenth century Ireland (O'Connor, 1978; Morgan and Grube, 1994). As Dean (1995) has shown in relation to the evolution of drinking practices in the Hebrides, and Herd (1985) in relation to the rapid late twentieth century increase in Black American cirrhosis rates, current drinking patterns are often relatively recent phenomenon, which "arise within the context of the social and material conditions of a given epoch" (Dean, 1995:277).

Cultural values and norms, transmitted within the family, are clearly important, in that they shape the way in which different ethnic groups use alcohol (O'Connor, 1978). These culturally-specific social rules are not fixed and immutable; rather they develop in interaction with other cultures and with political, social, and economic variables.

Earlier approaches to the study of drinking cultures ignored or oversimplified the complex interaction between ethnic identity, cultural norms, social structures, and economic factors like price and available income, often resorting to relatively crude characterizations of "Catholic" or "Protestant" cultures. More recent approaches have stressed complexity. Herd and Grube (1996), using structural equation modeling to study the impact of ethnic identity on religiosity and drinking norms, have shown that ethnic identity is multidimensional. In the United States, being Black means different things to different segments of the Black population, and different facets of Black identity affect drinking practices in different ways. It is unlikely that such complex interactions will be understood using techniques based on a model of linear causality; further theoretical advances are likely to come from the application of chaos theory, which can explain how patterns of behavior can "arise from the resolution of a very large number of internal and external influences, very many of which will be changing over time" (Dean, 1996).

A final argument against a reductionistic approach to cultural factors is that poor health has been observed among Irish migrants, not among the population in Ireland, which had the lowest all-cause mortality in the British Isles during the nineteenth century, with the exception of the famine years, 1847–1849 (Williams, 1992). Similarly, male mortality rates in Ireland and England have been similar for much of the late twentieth century, yet Irish men living in England have the worst health of any migrant group. And rates of alcohol-use-related mortality, which do not appear to be high in Ireland, are substantially raised among the Irish in England. The good health enjoyed by the Irish in Ireland seems to rule out genetic or cultural inheritance as the sole explanation for the poor health of the Irish overseas, unless a process of negative selection is in operation, whereby the least healthy migrate from Ireland.

Selection

It has long been known that migration is a selective process, and this selection can be positive, favoring the healthy, or negative, favoring the less healthy. Studies of migration and physicial health have shown that, in general, selection is positive: those who emigrate go on to have healthier lives than those they leave behind. Mortality for most immigrant groups in England is lower than in their country of birth and, in most cases, lower than in the host community (Marmot et al., 1984). Some early studies of psychiatric morbidity seemed to indicate that rates were higher for migrants, but later and more sophisticated studies have also shown that the foreign born have, in most cases, similar or better mental health than the native born (Cochrane and Bal, 1987).

The health of migrants from the Caribbean fits this general picture. Following migration in the 1950s and 1960s, rates of death from alcohol-use-related diseases among migrants from the Caribbean were much lower than among the UK national population. Although they appear to have increased over the last 12 years, this is still consistent with the "healthy migrant" hypothesis, as over time the pattern of health and morbidity among migrants will come to resemble that of the host community (see, for example, Egolf et al., 1992). The Irish and South Asians do not fit the picture of the healthy migrant. In this study, alcohol-use-related mortality has been consistently elevated for those of Irish and South Asian birth. It is possible that this is due to a process of negative selection, that is, to unhealthy people becoming migrants. Negative selection might occur when countries are near enough for migration costs and administrative barriers to be low, as in the case of Ireland and the UK, or where successful migrants could pay for extended family networks to join them, as was the case among many South Asians in the 1960s. Most South Asian people came to Britain from one of six relatively small regions in the subcontinent, and within these areas migration was concentrated in particular districts or villages (Henley, 1986).

Negative selection has been advanced as an explanation for Irish ill health, in particular, as Irish migrants are overrepresented in the unskilled manual labor employment category compared to the average for England and Wales (OPCS, 1993), so the possibility exists that a greater number come from disadvantaged groups that have higher than average rates of of alcohol dependence and mortality in Ireland.

There is some support for this explanation from history. From 1798, when 7,000 were forced to leave County Armagh following the Massacre of the Diamond, Irish migration was driven by religious and political persecution, high rents, land clearances, destitution, and famine. At the height of the exodus, in the 1880s, two-thirds of those born in Ireland were living outside the country (Jackson, 1963). Irish migrants were essentially refugees, and the relatively low all-causes mortality for those who were able to remain at home, and the very high mortality seen among the dispossessed, who died overseas, should be seen in this context.

Economic pressures continued to shape migration after the Second World War, with many forced to accept low status and ill-paid jobs in Britain. If negative selection is still a factor at the end of the twentieth century, however, it is of declining importance. Much of the disadvantage seen among respondents to Harrison and Carr-Hill's (1992) survey of 247 users of Irish welfare agencies seems to have arisen after their arrival in England. Thus, those who benefited from higher education in Ireland can be assumed to have received a good-enough start to life, yet many were unemployed or in relatively poorly

paid jobs in England. Thirty-eight percent of 51 graduates in Harrison and Carr-Hill's study had a weekly income below £175; in comparison, only 1.4% of those heads of households in England and Wales who belonged to a professional occupational group in the 1990 Family Expenditure Survey had incomes below this (Harrison and Carr-Hill, 1992: 21; Department of Employment, 1991). Similarly, 18% of graduates had not managed to acquire secure housing in England.

It seems possible, therefore, that the overrepresentation of the Irish in the lowest socioeconomic class in the 1990s reflects reduced access to employment and accommodation in England as much as negative selection. The same is likely to be true for migrants from the Indian subcontinent and from the Caribbean, who are also overrepresented in the lower socioeconomic classes, are more likely to be unemployed that White people, and report discrimination in the fields of employment and housing (Brown, 1984; OPCS, 1993). Further evidence on the significance of discrimination and disadvantage is discussed below.

Migration Stress

Migration stress is frequently identified with "culture shock," the short-term psychological consequences of exposure to unfamiliar environments (Furnham and Bochner, 1986). If culture shock was responsible for high mortality rates, it seems reasonable to hypothesize that the greater the sociocultural differences between the country of origin and the destination, the more pronounced will be the stress and the greater the subsequent problem rates. This is emphatically not the case here, where the Irish, who are arguably closer to the English in sociocultural terms than many other ethnic groups, have the greatest problem rates. To focus exclusively on culture shock, however, is to underestimate the importance of other migration stresses. These include the disruption of family and social networks, loneliness, problems over accommodation and employment, and changes to diet. Differences in the patterns of migration—such as whether men were accompanied by wives and families or were single—might explain some of the variation in problem rates.

Generally, however, the longer the length of stay in Britain, the less influence the process of migration is likely to have on mortality. For the South Asian and Caribbean groups, primary immigration virtually ceased following the 1971 Immigration Act. Irish immigration continues, though numbers are reduced and most Irish migrants are long-term residents: according to the 1991 Census, 72% of the Irish community in England and Wales are aged over 40 years (OPCS, 1993).

For the South Asian, Caribbean, and Irish groups, the length of stay is sufficient for short-term migration stress to cease to be a major influence on health. Further research is needed into whether high risk drinking patterns could be triggered by the stress involved in migration, leading to alcohol-use-related mortality in the long term, but the evidence that excessive all-cause and alcohol-use-related mortality persists into the second generation for the Irish suggests that more is involved than "culture shock." These long-term effects could be due to either acculturation stress or the accumulation of adverse experiences in the years following migration.

Acculturation

Acculturation refers to the longer term outcomes of contact between two cultures, including the changes that take place to the cultures of migrant groups in the process of assimilation. Acculturation is a hypothesis which has been explored much more thoroughly in North America than elsewhere, particularly in relation to Mexican-Americans and Puerto Ricans (see, for example, Black and Markides, 1993). It is held that over time the behavior and health status of migrant groups will come to resemble more closely the population they have entered than the population they have left behind. In some cases, adaptation to a new culture will be problematic, resulting in increased problem rates. For most migrant groups in the UK, like the French, rates of problems are intermediate between country of origin and the country of adoption (Marmot et al., 1984). The group which stands out as an exception is the Irish, where mortality appears to be higher than in the country of origin and where more complex processes are clearly at work. Further research is needed to understand whether and how alcohol-use-related problems are related to acculturation stresses for the Irish.

Disadvantage

Although the pattern of migration from Ireland is changing as a result of greater prosperity, Ireland traditionally supplied England with seasonal and migrant workers, especially in the construction industry. Many in the Irish community will have experienced poor working conditions, insecure employment, homelessness, and poor quality lodgings for much of their working life: conditions that are known to be associated with high levels of substance problems (Asogwa, 1993; McCaw, 1991; National Migrant Resource Program, 1991). The Caribbean and South Asian groups were also recruited in the 1950s and 1960s to fill low status jobs in England, and remain concentrated in unskilled and semiskilled jobs (Brown, 1984; OPCS, 1993). Occupational status

may well be an additional risk factor for the development of alcohol problems for many in the Caribbean, South Asian, and Irish communities.

This is not to argue that high rates of alcohol-use-related problems are an artifact of the migrant populations being concentrated in the lower social classes; Irish migrants in the nonmanual classes are also more likely to drink at high risk levels than the national population (Greenslade et al., 1995). First and second generation Irish have higher all-cause mortality than the national population in every social class (Raferty et al., 1990; Harding and Balarajan, 1996). Material disadvantage, while important, is not the only factor at work, otherwise Irish people in the highest socioeconomic classes would not be exhibiting such relatively high mortality. An additional risk factor might be discrimination against the Irish and Black groups, which, it has been argued, is the primary reason for their restricted access to employment and accommodation (Brown, 1984; Ohri and Faruqi, 1988). The experience of racism, discrimination, and, on occasion, racially motivated violence is one thing that links these culturally dissimilar ethnic groups and which is not, on the whole, shared by migrants from other parts of the world. Racist abuse, which escalates for the Irish during IRA bombing campaigns in England, presents a unique set of stressors which may contribute to the health outcomes observed in this study.

CONCLUSION

There are three main findings from this study. First, Black people appear to have broadly similar patterns of drug use to White people in England and Wales, but are overrepresented in the prison population for drug offences and underrepresented in the treatment population. This seems to reflect police enforcement priorities and sentencing bias rather than differences in offending behavior, and may be related to institutional racism within the British health and criminal justice systems.

Second, alcohol-use-related mortality appears to be high for Black immigrants. Earlier studies showed relatively low levels of alcohol consumption and related harm among first generation Caribbean migrants to England, but those born in the Caribbean no longer appear to be in such an advantageous position in the 1990s. Given the small sample size in this and previous studies, it is not possible to quantify precisely how much their health status has deteriorated. People who have migrated to England and Wales from the Indian subcontinent also have high alcohol-use-related mortality. There is considerable ethnic variation within the Caribbean and South Asian country of birth groups, however, so it cannot be assumed that the rate of increase is consistent across ethnic groups.

The third finding is that Irish migrants have substantial excess mortality from alcohol-use-related diseases—whether compared to the population in England and Wales or in Ireland—and there is no sign of any improvement over a 12-year period. The stability of mortality rates over time for the Irish and South Asian groups, and the deterioration seen for the Caribbean group, indicate that short-term migration stress is not the explanation for high rates of alcohol-use-related problems. While an element of negative selection cannot be ruled out for the Irish group, the adverse postmigration experiences reported by many well-educated Irish migrants suggests that something more is at work. The Caribbean, South Asian, and Irish groups share the experience of racist discrimination in Britain, which is known to be a major source of psychological stress.

A comprehensive and convincing explanation of the ethnic variations observed here would need to encompass the interaction between social structural factors like poverty, homelessness, and the employment conditions of migrant labor; economic factors like price and available income; demographic factors like the relationship between migration and marital status; the differing responses to stress within specific cultures; and the often related phenomena of acculturation and alienation. Future researchers need, therefore, to be able to model complex interactions between multiple variables. Recent developments in chaos theory, and nonlinear techniques such as artificial neural networks, might provide a way forward by enabling researchers to conceptualize and analyze complex and interrelated biopsychosocioeconomic phenomena.

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NOTES

1. Cannabis Psychosis, or Cannabis Delusional Disorder (DSM-III-R 292.11), is an organic psychotic disorder occurring after the consumption of cannabis.
2. High risk drinking is defined as weekly consumption over 35 British units for women and 50 units for men. One unit is equivalent to 8 g of pure alcohol.
3. In the UK the Standardised Mortality Ratio (SMR) is the preferred method for adjusting for age and sex when comparing populations. It does not require age-specific death rates for each population, avoids the distortions inherent in direct standardization when age distributions vary markedly, and is less affected by small numbers of deaths in the age-specific immigrant populations.

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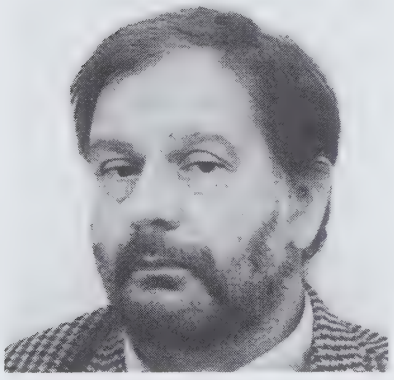

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Substance Use Patterns among Homeless Migrants and Nonmigrants in Chicago

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ABSTRACT

This paper uses data abstracted from 465 client records randomly selected from the current files of a downtown medical clinic in Chicago, Illinois to examine substance use among 85 immigrant and 380 nonimmigrant homeless and "at-risk" homeless adults. Immigrants to the United States reported lower levels of current cigarette, alcohol, and drug use compared to nonimmigrants in the sample. Immigrants were also less likely to report potential substance user treatment needs. Immigrants, however, did not differ from nonimmigrants in the reported quantity or frequency of cigarette and alcohol use. Drug use among homeless immigrants was also higher than estimates of misuse in the general population. The literally homeless in the sample reported higher levels of substance use compared to "at-risk" homeless. The literally homeless were also more likely to report higher levels of consumption and were more likely to have potential substance user treatment needs. The role of stress in the etiology of substance misuse among homeless immigrants and nonimmigrants is discussed. Implications for the treatment of these diverse populations are also addressed. [Translations are provided in the International Abstracts Section of this issue.]

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Key words. Immigrants; Hopelessness; Substance use; Substance user treatment

INTRODUCTION

It is estimated that the average number of immigrants entering the United States each year increased from 252,000 in the 1950s to 447,000 between 1960 and 1988 (US Immigration and Naturalization Service, 1993). During this period, the origins of the immigrant flows to this country shifted away from more developed countries in Europe and toward developing countries in Asia and Latin America. These new immigrants are more phenotypically, culturally, and linguistically visible compared to traditional immigrant populations to this country. Partly as a result of this increased visibility, the United States is currently confronting a quandary created by an open-door policy legacy on the one hand and a growing "politics of resistance" motivated by concern about possible deleterious effects of immigration on society and the economy on the other (LeClere et al., 1994). While always controversial, federal admissions policies for immigrants have now come under increased scrutiny and were a major issue in the 1996 presidential election.

At the center of this debate is the relative impact of immigration on American society, culture, and economy. Although current policies require evidence of social or economic support at the time of admission, some immigrants fail in their attempts to become self-sufficient and fall into extreme poverty and even homelessness (Subcommittee on International Law, Immigration, and Refugees, 1993). Little is known about these "high risk" populations, the unique stressors that confront them, and the extent and etiology of substance use/misuse among homeless immigrants. The focus of this paper will be an investigation of the substance use patterns of homeless immigrants, and a comparison with those of other homeless persons. We also explore the effects of social and economic resources in the etiology of substance misuse, and examine the treatment needs of these populations.

Until recently, sociologists conceptualized life events, such as migration and homelessness, as acute stressors, similar to other events (i.e., death of a spouse, loss of a job, etc.) that required adaptation on the part of the individual (Dohrenwend and Dohrenwend, 1981; Rabkin and Struening, 1976). While they remain important in the stress process, the effects of acute experience have been shown to dissipate quickly (Avison and Turner, 1988). Current research is more likely to classify experiences such as migration or homelessness as enduring strains rather than acute events because they often represent unresolved persistent difficulties. Other chronic strains include unemployment, divorce, physical disability, serious illness, and interpersonal conflict with family members and friends (Avison and Turner, 1988). Ultimately, all chronic strain

can be traced back to various systems of stratification such as those based on social and economic class, race, ethnicity, gender, and age (Pearlin, 1989). It is generally assumed that the unequal distribution of resources, opportunities, and self-regard inherent in such systems expose the individual to certain role strains that make them more vulnerable to distress (Avison and Turner, 1988). Because of their resilience, chronic strains are considered to be more likely to provoke mental or physical distress (Avison and Turner, 1988; Eckenrode, 1984; Pearlin and Schooler, 1978; Pearlin et al., 1981; Wheaton, 1983). Chronic strain has also been implicated in a greater overall tendency to misuse alcohol and other drugs (Tucker, 1985a; Timmer et al., 1985; Wills and Shiffman, 1985).

Several models of substance use processes among homeless and immigrant populations are presented in Table 1. Of these, the environmental stress and the acculturative stress models suggest that misuse emerges as a maladaptive coping response to enduring strains (Berry et al., 1987; Crutchfield and Gove, 1984; Gottheil et al., 1987; Pearlin and Radabaugh, 1976; Pearlin and Schooler, 1978; Timmer et al., 1985). Support for environmental stress and acculturative stress models have been mixed, however (Peyser, 1993). Alternative models have emphasized processes of socialization, assimilation, cultural identification, and self-medication. As conceived, however, migration and homelessness clearly represent persistent strains, conditioning broad segments of life. Both conditions are also often bereft of the social support resources. The sense of alienation produced by geographical, cultural, or social isolation may prompt a reliance on alcohol and other drugs as a mechanism to cope with life circumstance, which can ultimately lead to problem use. The objective stress and social isolation associated with homelessness and immigration make it difficult to ignore either as factors in the etiology of substance misuse among these populations.

Migration and Substance Use

In recent decades, substance misuse has become a major health and social problem within the immigrant community in the United States (see Table 2) (Alcocer, 1982; Caetano, 1984; Chi et al., 1989; Gilbert and Cervantes, 1986; Gordon, 1985; Page et al., 1985; Trimble et al., 1987). Not all immigrants are affected equally, however, as culture and gender also interact to produce a wide variety of substance use patterns among immigrant groups (Cheung, 1991). Hispanic immigrants, for example, have been shown to be particularly heavy drinkers (Caetano, 1984, 1988; Cervantes et al., 1991; Gilbert and Cervantes, 1986). Immigrants from Asian countries, in contrast, are much less frequent users and misusers of cigarettes, alcohol, and other drugs (Chi et al., 1989; Johnson et al., 1987; Sue et al., 1985). Women in all ethnic groups face

Table 1.

Selected Models of Substance Use among Homeless and Immigrant Populations: Critical Parameters and Processes

Model	Foci	Demands	Process	Limitations	References
Adaptation-environmental stress	Homeless persons	Resolve enduring strains (e.g., loss of economic resources, loss of social support, victimization, and hopelessness/depression)	Substance use to cope with strains	Direction of causality remains unresolved; little empirical evidence	Wright (1989)
Adaptation-socialization	Homeless persons	Adaptation/integration to "street environment"	Acceptance of "street" substance use norms	Direction of causality remains unresolved; little empirical evidence	Grigsby et al. (1990).
Adaptation-self-medication	Homeless persons	Ameliorate physical and mental health symptoms	Substance use to self-medicate	Direction of causality remains unresolved; little empirical evidence	Docter (1967)
Acculturative stress	Immigrants/refugees	Resolved enduring strains (e.g., culture shock, loss of social support, language barriers, loss of social status, and hopelessness/depression)	Substance use to cope with strains	Substance use for coping may be culture specific; does not account for migrant selection	Berry et al. (1987)
Assimilation	Immigrants/refugees	Adaptation/integration to host culture	Acceptance of host norms governing substance use	Assimilation may be multidimensional	Fernandez-Pol et al. (1985)
Orthogonal cultural identification	Immigrants/refugees	Strong identification with one or more cultures	Substance us associated with lack of identification with either host or native culture	Little empirical evidence	Oetting and Beauvais (1990-91)

Table 2.

Homelessness, Immigration, and Substance Use: Selected Parameters and Studies

Author	Location	Year(s) of study	N[a]	Homeless definition[b]	Sample sites[c]	Estimate	Definition	Drug type	Time interval	Study limitations
					Homeless—Alcohol Use/Misuse					
1. Breakey et al. (1989)	Baltimore, MD	1986-87	125M	LH	MI, SH, JA	68.1	Any alcohol disorder		Current/remission	Few limitation
			78F		SH, JA	31.6	Any alcohol disorder		Current/remission	
2. Smith and Spitznagel (1992)	St. Louis, MO	1989-90	600M	LH, AH	SH, ST	62.9	Alcoholism		Lifetime	All male sample
						49.8	Alcoholism		Last year	
						46.9	Alcoholism		Last 6 months	
						36.5	Alcoholism		Last month	
3. Sosin et al. (1988)	Chicago, IL	1986	345T	LH	SH, TP, SK	60.6	Self-reported use		Last month	Few limitations
					Homeless—Drug Use/Misuse					
4. Breakey et al. (1989)	Baltimore, MD	1986-87	125M	LH	MI, SH, JA	22.4	Misuse/dependence	Any drug	Current/remission	Few limitations
			78F		SH, JA	16.7	Misuse/dependence	Any drug	Current/remission	
5. Lambert and Caces (1995)	Washington, D.C.	1991	874T	LH, AH	EN, SH, SK, ST	76.0	Self-reported use	Marijuana	Lifetime	Few limitations
						66.1	Self-reported use	Cocaine	Lifetime	
						24.5	Self-reported use	Needle use	Lifetime	
						37.9	Self-reported use	Marijuana	Last year	
						49.3	Self-reported use	Cocaine	Last year	
						14.6	Self-reported use	Needle use	Last year	
6. Smith and Spitznagel (1992)	St. Louis, MO	1989-90	600M	LH, AH	SH, ST	39.7	Drug use disorder	Any drug	Lifetime	All male sample
						17.6	Drug use disorder	Any drug	Last year	
						14.1	Drug use disorder	Any drug	Last 6 months	
						8.2	Drug use disorder	Any drug	Last month	
7. Sosin et al. (1988)	Chicago, IL	1986	345T	LH	SH, TP, SK	56.1	Self-reported use	Marijuana	Current	Few limitations
						46.4	Self-reported use	Cocaine	Current	
						33.9	Self-reported use	Heroin	Current	

(*continued*)

Table 2. *Continued*

Author	Location	Year(s) of study	N[a]	Homeless definition[b]	Sample sites[c]	Estimate	Definition	Drug type	Time interval	Study limitations
					Immigrant—Alcohol Use/Misuse					
8. Chin et al. (1991)	New York, NY	NA	70M	IM	TP	19.0	Alcohol abuse		Lifetime	Small, all male sample. Clinic sample
						75.0	Alcohol dependence		Lifetime	
9. D'Avanzo et al. (1994)	Long Beach, CA	NA	60F	IM	RH	18.3	Self-reported use		Lifetime	Small, all female sample. Snowball sample
	Lowell, MA		60F	IM	RH	57.0	Self-reported use		Lifetime	
10. Tommasello et al. (1993)	Washington, D.C.	1989	76T	RIY	CS	78.6	Self-reported use		Ever used	Small sample. Convenience sampling
						58.9	Self-reported use		Past year	
						50.0	Self-reported use		Past month	
					Immigrant—Drug Use/Misuse					
11. Tommasello et al. (1993)	Washington, D.C.	1989	76T	RIY	CS	61.4	Self-reported use	Any drug	Every used	Small sample. Convenience sampling
						33.3	Self-reported use	Any drug	Past year	
						29.8	Self-reported use	Any drug	Past month	

[a]T = total sample, M = male, F = female.
[b]IM = immigrants, LM = literal homeless, AH = at risk homeless, RIY = runaway immigrant youth.
[c]CS = convenience sample, EN = encampments, JA = jails, MI = missions, RH = respondent homes, SH = shelters, SK = soup kitchens, ST = street/outdoor locations, TP = treatment programs.

a double standard which makes substance use more acceptance for men than women (Caetano, 1988; Chi et al., 1989; Gilbert, 1987; Harrell et al., 1980; Holock et al., 1984; Kitano et al., 1985; Legge and Sherlock, 1991; Page et al., 1985; Trotter, 1985; Wanberg et al., 1978). The greater gender differences among immigrants compared to United-States-born men and women result in a circumstance where immigrant women differ from their United-States-born counterparts much more than immigrant men differ from United-States-born males.

According to the acculturative-stress model, migration is interpreted as a major life event and has been linked with numerous stressors and stress responses (Berry et al., 1987; Cohen, 1987; D'Avanzo et al., 1994; Golding and Burnam, 1990; Kinzie et al., 1990; Mirdal, 1984; Stepick and Portes, 1986; Van Deusen, 1982; Vega et al., 1987). During migration, immigrants are quickly separated from familiar social, cultural, and environmental support systems (Cohen, 1987; Vega et al., 1987; Vega and Kolody, 1985; Warheit et al., 1985). Unless families immigrate en masse, or unless immigrants have family or friends awaiting them at their destination, this loss of support can lead to feelings of hopelessness or depression. Such feelings are only aggravated by the many difficulties encountered by immigrants during attempts to develop new support networks within the host country (Rogler et al., 1987; Warheit et al., 1985). Many immigrants are also inordinately challenged by the tasks associated with adaptation to their new environment (Cohen, 1987; Golding and Burnam, 1990; Rogler et al., 1978; Warheit et al., 1985). The lower social strata into which many immigrants enter makes them extremely vulnerable to stress and has an ongoing impact on the levels of distress experienced during migration (Berry et al., 1987; Desbarats, 1986; Vega et al., 1987; Westermeyer et al., 1983). When economic access or even the perception of economic opportunity in the host community is restricted or denied, acculturative stress becomes a dominant factor in the lives of many immigrants (Gordon, 1981, 1985; Vega et al., 1987, 1993). This disjunction between socially valued goals and even the hope of socially approved means is felt most by poorer immigrants. Pressures for social-problem behavior stem from this disjunction, placing unskilled immigrants at greatly increased risk of misuse of alcohol and other drugs. Problems with language, housing, and the various strains associated with living in an unknown world only compound this distress and increase the risk of psychopathology, including substance misuse, within this population (Golding and Burnam, 1990; Vega et al., 1987, 1993).

Assimilation models have also been employed in the literature to account for increased substance use among immigrants (Caetano, 1987a; Fernandez-Pol et al., 1985; Sue et al., 1985). According to this perspective, increases in use of alcohol and other drugs are in part a direct result of exposure to and gradual acceptance of dominant society norms and practices governing substance use

(Blane, 1977; Caetano, 1987a, 1987b; Chi et al., 1989; Gilbert, 1987; Sue et al., 1985). This model also suggests that attachment to nation-of-origin beliefs and values among recent immigrants from cultures that condemn substance use might also contribute to lower levels of usage compared to levels found among later generation immigrants, those socialized in cultures with fewer prohibitions against substance use, and among the general host population (Caetano, 1987a, 1988; Cervantes et al., 1991; Vega et al., 1993). Consistent with this model, several empirical studies have presented evidence indicating that recent immigrants to the United States are less likely to be substance users and misusers (Caetano, 1987a, 1987b; Cervantes et al., 1991; Fernandez-Pol et al., 1985; Graves, 1967; Holock et al., 1984). Numerous other models have also been proposed. Oetting and Beauvais (1990-91), for instance, have outlined the orthogonal cultural identification model. This framework suggests that cultural identification is multidemensional and those immigrants who are able to develop strong attachments to multiple cultures may be at lowest risk for substance misuse. Conversely, immigrants alienated from both their native and host cultures may be at greatest risk.

Homelessness and Substance Use

Substance misuse has long been acknowledged as a serious health and social problem among homeless persons (see Table 2) (Bahr and Caplow, 1974; Baumohl and Huebner, 1991; Bogue, 1963; Committee on Health Care for Homeless People, 1988; Fischer, 1989; Fischer and Breakey, 1991; McCarty et al., 1991; Morgan et al., 1985; Milburn, 1989; Straus, 1946; Welte and Barnes, 1992). Homeless men continue to be the most likely consumers of both alcohol and drugs. Alcohol-related habits and treatment needs are the most common among older homeless males. Younger minority males are most likely to use drugs and to have substance user treatment needs (Fischer and Breakey, 1991).

Stress and stress responses have been implicated as a cause and consequence of homelessness (Baxter and Hopper, 1981; Breakey et al., 1995; Jahiel, 1987; La Gory et al., 1990; Morse and Calsyn, 1986; Schutt et al., 1994). The combined loss of job, housing, and possessions is devastating to an individual and can lead to feelings of depression and despair. Moreover, the newly homeless must confront a foreign and often confusing living environment anchored by social service agencies and characterized by poor health conditions, victimization, and crime (Brickner et al., 1985; Committee on Health Care for Homeless People, 1988; Fischer and Breakey, 1987; Solarz, 1986). While adversity is abundant, social support among the homeless is limited at best (Baxter and Hopper, 1981; Gelberg and Linn, 1989; La Gory et al., 1990; Rossi and Wright, 1989; Shinn et al., 1991; Solarz and Bogat, 1990). With

few economic opportunities and limited social resources, some of the homeless and marginally housed turn to alcohol and other drugs in an effort to cope with the stress and alienation of life on the margins of society (Morgan et al., 1985). This reliance on substance use as a coping mechanism presents sizable barriers to effective treatment within this population (Baumohl and Huebner, 1991; Committee on Health Care for Homeless People, 1988; Drake et al., 1991; Morgan et al., 1985). Furthermore, the misuse of alcohol and other drugs compounds the stress of homelessness by contributing to an increased risk of serious physical and mental health problems, criminal victimization, and chronic dependence (Baumohl and Huebner, 1991; Fischer and Breakey, 1991; Morgan et al., 1985; Struening and Padgett, 1990; Wright, 1990; Wright et al., 1987).

While the stress of homelessness is acknowledged, there are alternative explanations for the widespread use of alcohol and other drugs among this population. Socialization to the homeless environment, for example, has been implicated as a primary cause of substance use and misuse. Because homelessness often limits affiliations to other homeless individuals, the condition devalues even the limited amount of social support available and greatly increases the likelihood that an individual will continue to function outside of traditional roles (Grigsby et al., 1990; Snow and Anderson, 1993). Together, social isolation and the affiliation with homeless networks may lead to an entrenchment of the homeless condition and increased risk of stress-related illnesses, psychopathology, and substance misuse (Grigsby et al., 1990). Others have suggested that homeless individuals may use substances as a form of self-medication to alleviate, however temporarily, physical or mental health symptoms (Wright, 1989).

METHODS

The data for this analysis consist of information abstracted from clinical charts of homeless and transients receiving primary and preventive care at a large community health clinic in Chicago, Illinois. Persons who are homeless or transient are known to face significant barriers to health care (Committee on Health Care for Homeless People, 1988; Elvy, 1985; Robertson and Cousineau, 1986; Stark, 1992). Also included within this patient pool are noncitizen immigrants, a group that may encounter cultural, as well as economic, barriers to health care (Berkanovic and Telesky, 1985; Chavez et al., 1985; Jensen, 1989; LeClere et al., 1994; Roberts and Lee, 1980). This community clinic is part of an innovative effort to provide medical services to these individuals who would otherwise have little or no access to quality care. Many of the clinic's programs are designed for specific ethnic groups or ethnic subgroups. Services are also delivered to special needs populations by a variety

of methods including satellite clinics located in shelters, mobile med teams, and drop-in centers strategically placed throughout the city. At each site, health services are provided by physicians and nurse practitioners. Medical records are kept at the community clinic.

Record abstraction was conducted during the winter of 1994 as part of a larger study of homelessness and health. Based on a random sample of current clinic charts, a total of 465 medical records were reviewed by the first author. Data were systematically abstracted using the extensive risk assessments, diagnosis charts, treatment plans, and treatment process notes contained in client files. Information taken from the charts included demographic information, housing and employment status, insurance coverage, legal status, substance misuse, and homeless experiences.

Defining Migrant Status and Homelessness

Individuals who have citizenship in another country but have been granted legal entrance to the United States are considered to be immigrants. Such individuals generally fall under one of four basic categories: family-based immigrants, employment-based immigrants, refugees, and undocumented aliens (Subcommittee on International Law, Immigration, and Refugees, 1993). Family-based immigrants come to the United States to be reunited with family members who have become permanent residents or citizens of the United States. Employment-based immigrants are granted visas for United States employment in job areas in which a labor shortage exists. Refugees, in contrast, are individuals who are unable or unwilling to return because of persecution or a well-founded fear of persecution. Undocumented aliens are illegal immigrants to the United States. For the purpose of this study, immigrants were all individuals reporting to be noncitizens during the course of the clinic's intake interview. Included in this definition are immigrants by more traditional definitions ($n = 45$ employment- or family-based) as well as refugees ($n = 5$) and undocumented and legalized (amnesty) aliens ($n = 35$). The remaining 380 persons in the sample were United States citizens.

The absence of a widely accepted definition of homelessness remains an obstacle to collecting credible data from this group (Peroff, 1987; Rossi, 1989; Rossi and Wright, 1989). A sampling of the variety of definitions of homelessness is presented in Table 3. Highly restricted definitions of the "literal homeless" include only those without a roof over their heads (Caton, 1990; Rossi, 1989; Susser et al., 1993). Included in this definition are the stereotypical homeless: people with nowhere else to go other than the streets or the overnight shelters provided by public and private agencies.

Literal definitions of homelessness have often been criticized as being too narrow, and attempts have been made to expand the definition to include the

Definitions of Homelessness

Author	Definition	Basic parameters	Policy considerations	Advantages	Disadvantages/limitations
Jahiel (1987)	Benign and malignant homeless	Benign homelessness is associated with relatively little hardship, lasts for a relatively short time, and does not recur often. Malignant homelessness is associated with considerable hardship, lasts for a relatively long time, and recurs often	Definition encompasses a broad range of housing situations. Does distinguish between groups of possible policy interest	Attempts to address the complexity of the problem	Not clear as to the amount of hardship distinguishing different groups. Difficult to operationalize
Johnson and Barrett (1995)	Literal homeless and at-risk homeless	Literal homeless are people without a roof over their heads. At-risk homeless are individuals with a very precarious claim to housing	Distinguishes literally homeless from the marginally housed, but includes the marginally housed as part of the homeless population	Develops a more complete understanding of homelessness. Still able to identify populations of likely policy interest	Not clear what constitutes a "precarious" claim to housing
Johnson (1989)	Homelessness defined in terms of degree of deprivation	Condition reviewed as a variable, with the intersection of time (duration/repetition) and place (continuum between substandard housing and literal homelessness) forming a framework for conceptualizing severity	Intersection between dimensions of time and place requires the charting of residential experiences rather than the measurement of housing status at any one time	Attempts to address the complexity of the problem	Arbitrary. Not clear at which point people become homeless. Difficult to operationalize
Rossi and Wright (1989)	Literal homeless	Individuals who do not have customary and regular access to a conventional dwelling or residence	Definition distinguishes the literally homeless from the marginally housed. Literally homeless are those who have fallen below the floor of housing adequacy	Definition clearly specifies populations of likely policy interest	Not clear what is "customary" or "regular" access

socially isolated or those with only a precarious claim to housing (Bachrach, 1984; Jahiel, 1987; Ropers and Boyer, 1987; Roth and Bean, 1986). Because many persons experiencing homelessness move into and out of this condition on multiple occasions, research focusing on the literal homeless only may overrepresent long-term and chronically homeless persons, thereby painting a distorted picture. Also examining at-risk groups may help alleviate this problem. Johnson and Barrett (1995), for instance, examined groups of literally homeless and persons "at-risk" for homelessness, the latter being defined as persons living in single room occupancy (SRO) hotels. Their analysis demonstrated both similarities and differences across these groups.

The patient pool of the health care clinic from which records were sampled for this study also provides the opportunity to investigate the patterns of substance use among both homeless persons and a group of transient persons at-risk for homelessness. For the purpose of this study, the "literal homeless" are individuals who lack a permanent and regular residence within a conventional dwelling unit ($N = 328$). Included here are the stereotypical homeless mentioned above. "At-risk homeless" are precariously or marginally housed persons with only tenuous or very temporary claims to a conventional dwelling. Among the at-risk homeless in this study are individuals residing in SROs and other overcrowded or physically inadequate housing ($N = 137$).

Measurement and Analysis

Client charts contained detailed questions regarding current use of a variety of substances, including cigarettes, alcohol, and illicit drugs (definitions of alcohol and each illicit drug are provided in the Glossary beginning on page 1011). Quantity of cigarette was measured in packs per day; information regarding number of years smoked was also collected. Alcohol use was classified as "heavy" if an individual reported daily use or the consumption of at least 6 drinks per week. A similar classification was made for each drug based on an individual's report of weekly or daily drug use. Multiple drug use was determined based on the reported number of drugs currently being used.

Current need for substance misuser treatment was measured using eight items the clinic had adapted from the CAGE questionnaire. Previous research has demonstrated the CAGE to be an effective, yet nonthreatening, method for screening for alcoholism (Ewing, 1984; Steinweg and Worth, 1993). The modified version used by the clinic included the four items commonly used to measure alcoholism and an additional four items revised to collect information regarding drug use dependency. In this study a single affirmative answer to any of the eight CAGE items was considered sufficient enough to warrant suspicion of substance misuse and a need for treatment. Unmet treatment needs in

both groups were identified by estimating the proportions of those indicating drug or alcohol misuse but who reported having never received such care.

Employment status was a dichotomous variable, classifying individuals as either employed (full-time or part-time) or unemployed. Marital status was also dichotomous, identifying individuals as either currently married or not married. Those who had been divorced, widowed, separated, or never married were included in the latter classification. During intake, patients were asked if they had any history of drug or alcohol misuse treatment (either inpatient or outpatient). Patients were also asked at that time if they were currently experiencing a moderate or severe medical problem (Health Status).

Initial analyses examined current prevalence rates of tobacco, alcohol, and drug use, and drug use administration via needles, among these populations, as well as current treatment needs. Probit models (Aldrich and Nelson, 1984) were subsequently used to estimate the independent associations of migration and homeless experiences with each of these measures. Indicators of current marital and employment status were also examined in these models. Each model also controlled for several sociodemographic variables, including age (in years), gender, race (indicators representing Blacks and Hispanics, contrasted with all others), and education.

RESULTS

Sample Characteristics

Demographic and other background characteristics for the total sample, and separately for the immigrant and nonimmigrant subgroups, are presented in Table 4. In general, most persons in the sample were literally homeless at the time of their first contact with the clinic. A majority were male, Black, age 35 or older (average age = 36.7 years), and had a high school education. Few social and economic resources were available to this population, as large proportions were not married and were currently unemployed. One in five reported currently having moderate or severe health problems. Just under a third reported histories of treatment for alcohol or drug use.

Several important differences between the migrant and nonmigrant subgroups were observed. Nonmigrants were more than twice as likely to have been literally homeless at the time of their initial contact with the clinic (79.5 vs 30.6% of migrants). A majority of the migrants were Hispanic (67.1%), and the nonmigrant sample was primarily Black (62.1%). Most migrants reported less than a high school education (77.6%) while most nonmigrants did complete high school (64.5%). Migrants, however, were more likely to report being currently employed full or part-time (30.6 vs 13.4%) and currently married (40.0 vs 4.5%). Nonmigrants were more likely to report having pre-

Table 4.

Selected Demographic Characteristics, by Sample (percent)

Demographic characteristics	Migrant sample (N = 85)	Nonmigrant sample (N = 380)	Total sample (N = 465)
Housing status:**			
Literal homeless	30.6	79.5	70.5
At-risk homeless	69.4	20.5	29.5
Gender:			
Male	45.9	56.6	54.6
Female	54.1	43.4	45.4
Race:**			
Black	1.2	62.1	51.0
Hispanic	67.1	3.9	15.5
Other:	31.8	33.9	33.5
Age:			
18–34	51.8	45.8	46.9
35+	48.2	54.2	53.1
Education:**			
Less than high school	77.6	35.5	43.2
High school +	22.4	64.5	56.8
Employment status:**			
Employed	30.6	13.4	16.6
Not employed	69.4	86.6	83.4
Marital status:**			
Married	40.0	4.5	11.0
Not married	60.0	95.5	89.0
Health status:			
Health problem	24.7	20.8	21.5
No problem	75.3	79.2	78.5
History of alcohol user treatment:**			
Yes	7.1	37.4	31.8
No	92.9	61.1	66.9
History of drug user treatment:**			
Yes	3.5	35.3	29.5
No	96.5	63.2	69.2

*$P < .05$.
**$P < .01$.

viously received alcohol (37.4 vs 7.1%) and drug (35.3 vs 3.5%) user treatment.

Current Cigarette Use

Current prevalence of cigarette use is presented in the second numerical column of Table 5. Cigarette smoking was common among the total sample,

Table 5.

Current Prevalence of Cigarette and Alcohol Use, by Sample/Demographic Characteristics

	N	Current cigarette	Current alcohol
Total	465	63.9	60.0
Sample:			
Migrant	85	32.9**	36.5**
Nonmigrant	380	70.8	65.3
Housing status:			
Literal homeless	328	72.6**	63.7**
At-risk homeless	137	43.1	51.1
Gender:			
Male	254	71.7**	74.0**
Female	211	54.5	43.1
Race:			
Black	237	71.3**	67.5**
Hispanic	72	40.3	50.0
Other	156	63.5	53.2
Age:			
18–34	218	62.8	62.4
35+	247	64.8	57.9
Education:			
Less than high school	201	62.7	58.7
High school +	264	64.8	61.0
Employment status:			
Employed	77	42.9**	59.7
Not employed	388	68.0	60.1
Marital status:			
Married	51	45.1**	37.3**
Not married	414	66.2	62.8
Health status:			
Health problem	100	65.8	58.0
No problem	365	57.0	60.5

*$P < .05$.
**$P < .01$.

with current use estimated to be 63.9%. Nonmigrants were more likely to report current use of cigarettes (70.8 vs 32.9%) compared to migrants. The literally homeless were also more likely to be current cigarette smokers (72.6 vs 43.1%) than were the at-risk homeless. In addition, males (71.7 vs 54.5% of females) and Blacks (71.3% vs 40.3% of Hispanics and 63.5% of other races) also had higher rates of current cigarette use. Persons unemployed (68.0 vs 42.9% of those employed) and not married (66.2 vs 45.1% of those married) were also more likely to be currently smoking cigarettes.

Regarding quantity of consumption (data not shown), 64% of the total sample reported smoking at least one pack of cigarettes per day. In addition, 49.2% of the total sample reported having smoked for 10 years or more. Quantity of cigarette use and length of experience did not vary by immigration or homeless status.

Current Alcohol Use

Prevalence of current use of alcohol is presented in the third numerical column of Table 5. Sixty percent of the total sample reported current use of alcoholic beverages. Nonmigrants were more likely than migrants to report current use of alcohol (63.3 vs 36.5%). In addition, the literally homeless were also more likely than the at-risk homeless to report current alcohol consumption (63.7 vs 51.1%). Gender and race differences in current alcohol use prevalence rates were also observed, with males (74.0 vs 43.1%) and Blacks (67.5 vs 50.0% of Hispanics and 53.2% of other races) indicating current use. Persons not currently married (62.8 vs 37.3% of those married) also had a lower rate of current alcohol use.

Overall, 49% of the sample were classified as heavy drinkers (data not shown). Immigrants did not differ from nonimmigrants in the amount of alcohol consumed. The literally homeless, however, were more likely than the at-risk homeless to report heavy use (73.7 vs 54.5%).

Current Drug Use

Prevalence rates of current drug use are shown in Table 6. More than half of the total sample (56.8%) reported current use of one or more drugs. The three drugs most commonly reported were cocaine (44.7%), marijuana (36.1%), and heroin (19.6%). Current prevalence of other drugs not shown in Table 6 include the following: PCP (11.2%), LSD (9.5%), amphetamines (6.5%), and prescription drugs (4.3%).

In general, immigrants reported considerably lower levels of any current drug use compared to nonimmigrants (14.1 vs 66.3%). Immigrants reported significantly lower use of marijuana (10.8 vs 44.3%), cocaine (7.2 vs 56.3%), and heroin (1.2 vs 25.1%). Immigrants were also less likely to report having used LSD (2.4 vs 11.7%), PCP (1.2 vs 14.2%), amphetamines (2.4 vs 7.8%), and prescription drugs (0.0 vs 5.6%). Persons who were literally homeless, on the other hand, were more likely to report current drug use compared to at-risk homeless (65.9 vs 35.0%). Literally homeless reported higher levels of marijuana (42.4 vs 28.6%), cocaine (57.2 vs 23.8%), and heroin (25.1 vs 4.2%) misuse. The literally homeless were also more likely to report having

Table 6.

Current Drug Use by Sample/Demographic Characteristics

	N	Any drugs	Marijuana	Cocaine	Heroin	Needle use
Total	465	56.8	36.1	44.7	19.6	16.1
Sample:						
Migrant	83	14.1**	10.8**	7.2**	1.2**	1.2**
Nonmigrant	359	66.3	44.3	56.3	25.1	19.5
Housing status:						
Literal homeless	311	65.9**	42.4**	57.2**	25.1**	19.2**
At-risk homeless	126	35.0	28.6	23.8	10.3	8.7
Gender:						
Male	244	65.4**	48.0**	53.0**	24.2**	21.7**
Female	198	46.4	25.8	40.0	16.2	9.5
Race:						
Black	225	67.5**	42.2	60.4*	23.1	16.0
Hispanic	70	26.4	18.6	15.7	4.3	6.9
Other	147	54.5	40.8	41.5	24.5	20.5
Age:						
18–34	205	59.6	43.9	48.3	20.0	15.1
35+	237	54.3	32.9	46.0	21.1	17.0
Education:						
Less than high school	192	49.8*	36.5	42.7	18.8	14.9
High school +	250	62.1	39.2	50.4	22.0	17.0
Employment status:						
Employed	72	31.5**	23.6**	23.6**	6.9**	3.9**
Not employed	383	61.1	39.4	49.9	22.5	18.6
Marital status:						
Married	48	27.5**	12.5**	20.8**	8.3**	5.9
Not married	394	60.4	41.1	50.2	22.1	17.4
Health status:						
Health problem	96	45.0*	33.3	37.5	22.9	16.0
No problem	346	66.0	39.3	49.7	19.9	16.2

*$P < .05$.
**$P < .01$.

used LSD (11.6 vs 6.3%), PCP (14.5 vs 5.6%), amphetamines (8.7 vs 2.4%), and prescription drugs (5.8 vs 1.6%). In addition, males (65.4 vs 46.4%), Blacks (67.5 vs 26.4% of Hispanics vs 54.5% of other races), persons with at least a high school diploma (62.1 vs 49.8%), the unemployed (61.1 vs 35.1%), those not married (60.4 vs 27.5%), and those without moderate/severe health problems (65.0 vs 45.0%) were also more likely to report current drug use.

Needle use was also reported by 16.1% of the sample. Far fewer immigrants (1.2 vs 19.5%) and persons "at risk" of homelessness (8.7 vs 19.2%) reported current use of needles. Use of needles was also lower among females (9.5 vs 21.7%) and persons who were unemployed (3.9 vs 18.6%).

"Heavy" drug use was examined for the top three drugs reported in the sample (data not shown). Of the total sample, 26.0% reported "heavy" use of marijuana, 35.9% indicated "heavy" use of cocaine, and 14.2% reported "heavy" use of heroin. Immigrants reported less "heavy" use of marijuana (7.1 vs 30.3%), cocaine (3.5 vs 43.2%), and heroin (1.2 vs 17.1%) compared to nonimmigrants. Those "at risk" of homelessness also reported less "heavy" use of marijuana (19.7 vs 28.7%), cocaine (17.5 vs 43.6%), and heroin (8.0 vs 16.8%) compared to the literally homeless in the sample.

Thirty-six percent of the sample reported having used two or more types of drugs (data not shown). Immigrants were more likely than nonimmigrants to report use of a single drug rather than multiple use patterns (4.7 vs 42.9%). The literally homeless, on the other hand, were more than twice as likely to report multiple use patterns (42.3 vs 20.5% for at-risk homeless).

Need for Treatment

Overall, approximately 56% of the sample were identified as currently having a potential need of substance misuser treatment based on their CAGE scores for alcohol and drug misuse (Table 7). A single affirmative answer to one of eight CAGE items was considered sufficient to warrant suspicion of misuse. By this standard, immigrants were considerably less likely to be identified as substance misusers than were the United States citizens in the sample (17.6 vs 63.9%). The literally homeless (67.1 vs 27.7%), the unemployed (60.6 vs 29.9%), and single respondents (59.2 vs 25.5%) were also more likely to be classified as misusers. In addition, males in the sample were more likely to be in need of treatment than were females (66.5 vs 42.2%), as were Blacks (64.1 vs 25.0% of Hispanics and 56.4% of other races) and the more educated (59.5 vs 50.2%).

Unmet treatment needs were estimated as the proportion of the sample identified as substance misusers who also reported having never received either inpatient or outpatient treatment. These findings revealed that approximately 17% of the sample had unmet treatment needs. No differences in unmet treatment needs by migrant and homeless status were identified. Males (22.11 vs 10.0%) and persons not married (17.8 vs 6.0%), however, were more likely to have unmet needs for treatment.

Comparisons to the General Population

While not intentionally patterned on the National Household Survey on Drug Abuse (NHSDA), the nature of the clinic data does permit some very rough comparisons between the homeless sample and the general adult popu-

Table 7.

Substance Misuse and Unmet Treatment Needs, by Sample/Demographic Characteristics

	N	Substance misuse	Unmet treatment needs
Total	465	55.5	16.6
Sample:			
Migrant	85	17.6**	10.6
Nonmigrant	380	63.9	17.9
Housing status:			
Literal homeless	328	67.1**	16.8
At-risk homeless	137	27.7	16.5
Gender:			
Male	254	66.5**	22.1**
Female	211	42.2	10.0
Race:			
Black	237	64.1**	17.7
Hispanic	72	25.0	15.3
Other	156	56.4	15.5
Age:			
18–34	218	51.4	16.2
35+	247	59.1	16.9
Education:			
Less than high school	201	50.2*	15.0
High school +	264	59.5	17.8
Employment status:			
Employed	77	29.9**	16.2
Not employed	388	60.6	16.6
Marital status:			
Married	51	25.5**	6.0*
Not married	414	59.2	17.8
Health status:			
Health problem	100	52.0	15.5
No problem	365	56.4	16.9

*$P < .05$.
**$P < .01$.

lation (data not shown). Comparisons were made with NHSDA estimates for large metropolitan areas (SMSAs with a 1980 population of at least 1 million) and the United States as a whole (National Institute on Drug Abuse, 1995). Current use of cigarettes among our full sample of literally and at-risk persons was more than double large metro (63.9 vs 26.6%) and national rates (63.9 vs 28.6%). Overall, current alcohol use was only slightly higher among the homeless compared to large metro populations (60.0 vs 56.6%) and the nation

as a whole (60.0 vs 53.9%). Dramatic differences in the prevalence of current drug use, however, were identified, with our sample reporting far higher levels of misuse compared to large metro populations (41.1 vs 6.1%) and the United States as a whole (41.1 vs 6.0%). These data further suggest that our sample of homeless and transient immigrants have only slightly higher prevalence of current cigarette use compared to populations in large metro areas (32.9 vs 26.6%) and to the United States total (32.9 vs 28.6%). The prevalence of any current drug use was also slightly higher within our immigrant sample compared to both metro populations (14.1 vs 6.1%) and the United States as a whole (14.1 vs 6.0%). The prevalence of current alcohol use, on the other hand, was considerably lower among immigrants compared to large metro populations (36.5 vs 56.6%) and the United States total (36.5 vs 53.9%). Again, the variations in the methodologies used to collect the household and homeless data suggest that these comparisons be interpreted with caution.

Multivariate Analyses

Probit models were next estimated to examine the independent effects of migrant and housing status upon substance use and misuse. In general, these findings confirm the earlier bivariate analyses that indicated less substance use and misuse among migrants, relative to nonmigrants. Similarly, males were also confirmed as being more likely to use and misuse the substances examined in each of these models. Persons who were literally homeless, those who were unemployed, and those without moderate or severe health problems were all more likely to be current users of cigarettes and drugs, and to be substance misusers. In addition, younger persons were more likely to be current drug users, and Blacks were more likely to report current alcohol use. When other variables were controlled in these models, marital status was unrelated to the substance use indicators.

DISCUSSION

The generalizability of the substance use estimates presented in this analysis may be questioned on a number of counts, including the validity of substance use reports and sample representativeness. While always troublesome to assess, the quality of self-report in clinic and other settings is made somewhat more difficult by the sensitive and sometimes illegal nature of the behavior in question (Ness and Ende, 1994). A focus on immigrants provides a further complication, as alcohol and other drug use differs across societies and there are widely divergent standards for what constitutes misuse (D'Avanzo et al., 1994; Gordon, 1985; Heath, 1990; Smart et al., 1988; Trimble et al., 1987; Westermeyer, 1987). Cultural beliefs may also affect utilization of alcohol and

other drug-related treatment services (Hoffman, 1994; Trimble et al., 1987; Tucker, 1985b). Immigrants have also tried to conceal misuse in an effort to avoid bringing disgrace on their family (Cheung, 1991) and to avoid deportation. Still, previous research does suggest that self-report of alcohol use is generally accurate, especially when obtained in clinical settings similar to that encountered in the Chicago health clinic (Giovannucci et al., 1991; Sobell and Sobell, 1990). Greater variability has been observed in self-reported use of other drugs (McNagny and Parker, 1992), with some authors suggesting a systematic underreport of misuse (Smart and Jarvis, 1981). Self-report among the homeless has been found to be as accurate as measures obtained from other groups (Calsyn et al., 1993).

With regard to sample representation, it is likely that the clinic sample represents a very select subset of the population in question. The degree to which transients presenting themselves for care at the clinic are an adequate representation of Chicago's homeless population is unknown (Wright et al., 1987). There is also no reason to believe that those immigrants seeking care at the clinic participating in this study are representative of the city's immigrant community (LeClere et al., 1994; Van Deusen, 1982). This clinic, however, does offer a unique opportunity to study simultaneously the substance use problems of homeless immigrant and nonimmigrant individuals because it provides continuity care to these two populations in the same setting (Ferenchick, 1992). And while the aggressive outreach strategy employed by the clinic fails to fully address the number of homeless addicts outside of the social service network (Gelber and Linn, 1989), it does improve overall representation. These qualifications, coupled with efforts among immigrants to conceal use and misuse, suggest that the prevalence rates presented would best be considered conservative estimates of alcohol and other drug use among homeless immigrants in Chicago.

The results of this study nonetheless suggest that problems with alcohol and other drugs, including tobacco, are an important issue among homeless immigrants in the United States. Although the problem is relatively small in comparison to the magnitude of the problem among other homeless in the sample, immigrant and nonimmigrant subgroups did not differ significantly in the percentage reporting heavy use of cigarettes or alcohol. They also did not differ in the overall frequency of substance use. Immigrant males, in particular, were more likely to report use of cigarettes, alcohol, and other drugs. They were also more likely to have potential treatment needs. These gender differences in substance use and misuse are consistent with previous research on use patterns among immigrants (Alcocer, 1982; Caetano, 1984; Cervantes et al., 1991; Chi et al., 1989; Holock et al., 1984; Kitano et al., 1985; Wanberg et al., 1978).

In addition, comparison of these clinic data with prevalence estimates from the National Household Survey of Drug Abuse provides evidence of the affects of acculturative stress on substance misuse. In contrasting these two samples, literal homelessness appears to be the stressor most strongly associated with increased use of tobacco, alcohol, and other drugs. For the immigrant, literal homelessness represents visible and damning evidence of their failure in acculturation. Economic access is effectively eliminated and at no point is the disjuncture between socially valued goals and socially approved means greater. Acute distress follows as the homeless migrant is forced to contront a wide variety of problems and situations that pose immediate threats to their emotional and physical well-being; all within a foreign and sometimes hostile environment. It should come as no surprise that some turn to tobacco use to provide a measure of immediate gratification (Johnson and Barrett, 1995). Misuse of alcohol and other drugs also becomes more likely as homeless immigrants attempt to deal with their stress-filled situation. Access to treatment is made problematic by barriers to service utilization common among the homeless (Baum and Burnes, 1993; Committee on Health Care for Homeless People, 1988) and the immigrants in this country (LeClere et al., 1994; Sonis, 1995; Velasco et al., 1995).

Yet, compared to nonmigrants, immigrants in this sample reported far less use of addictive substances, a finding consistent with other avaiable evidence regarding the substance use patterns of immigrants (Caetano, 1988; Cervantes et al., 1991; Gilbert, 1987; Trimble et al., 1987), Several potential explanations for the observed group differences in alcohol and other drug use patterns should be considered. First, a far lower percentage of the immigrant subgroup was literally homeless at the time of the interview. Given the high rates of use typically found in studies of literally homeless populations (Fischer and Breakey, 1991), it is also reasonable to suspect that differences in sample composition between the immigrant and nonmigrant samples may account for much of the observed variation across these two groups. While at-risk homelessness is by no means stress-free, it does represent a significant improvement over living on the streets. Second, information in Table 4 also suggests that the immigrant sample had greater access to stress-alleviating social and economic resources, as immigrants were more likely to have been married and be employed. In a series of multivariate analyses designed to examine the acculturative-stress mode (Table 8), these variables were unable to account for differences in substance use between the immigrant and nonmigrant samples. Differences between these groups may also reflect the truncated nature of the immigrant sample. The United States government screens out those individuals applying for entry who are diagnosed with substance use problems prior to immigration (Tipple et al., 1994).

Table 8.

Probit Coefficients for Substance Use and Misuse

Characteristics	Current cigarette use	Current alcohol use	Current drug use	Substance misuse
Sample (1 = Migrant)	-1.78*	-1.36*	-2.24*	-1.63*
Housing status (1 = Literal)	0.86*	0.13	0.58*	1.07*
Gender (1 = Male)	0.93*	1.36*	1.06*	1.09*
Black (1 = Yes)	-0.18	0.54*	0.07	-0.01
Hispanic (1 = Yes)	-0.01	0.76	0.09	-0.13
Age	0.02	-0.01	-0.04*	0.01
Education	-0.25*	-0.14	0.02	-0.18
Health problem (1 = Yes)	-1.03*	-0.14	-0.74*	-0.65*
Employment (1 = Yes)	-0.74*	0.10	-1.13*	-0.99*
Marital status (1 = Married)	0.22	-0.41	-0.07	-0.22
N	431	442	455	465
Chi square	427.63	435.19	441.22	469.40

*$P < .05$.

The most likely explanation though, and one that is consistent with the assimilation model, is that the negative relationship between legal status and current substance use may be the product of the large number of recent immigrants in the sample. As discussed earlier, research has shown recent immigrants to have less permissive attitudes regarding illicit substance use compared to later generations (Caetano, 1984; Gilbert, 1987; Legge and Sherlock, 1991), a finding consistent with the notion that recent arrivals are more likely to retain the values of their native culture. We are, unfortunately, not able to directly confirm this hypothesis because the information necessary to do so were not available in the data collected for this study. Examining length of time in their new location, as well as determing level of integration with host culture, should be an important goal for future research on substance use among immigrant and refugee populations.

The results from this study have important implications for treatment of alcohol and other drug misuse. Nontrivial treatment needs were revealed for immigrant and nonimmigrant as well as literal and at-risk homeless populations. Response to this need has been less than optimal. It is now recognized that traditional approaches to treatment, such as detoxification, fall short in their ability to care for homeless substance users (Breakey, 1987; Hopper, 1989; McCarty et al., 1991). Even more aggressive outreach strategies to reach this high-risk population should be considered (Savarese et al., 1990). There has also been the realization that existing treatment methods have failed to provide

fully for immigrant substance users (Legge and Sherlock, 1991; Trimble et al., 1987; Tucker, 1985b). From the literature it is clear that intensive or coordinated programs targeted at homeless immigrants will have to take into account ethnicity as well as level of acculturation in order to be effective (Hoffman, 1994; Legge and Sherlock, 1991; Tucker, 1985b). Levels of unmet need revealed in this study lend a sense of urgency to calls for more applied research in an effort to define factors related to initial use, subsequent addiction, and cessation of substance use among immigrants.

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Drug Problems among Immigrants and Refugees in the Netherlands and the Dutch Health Care and Treatment System

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ABSTRACT

Immigration from former colonies and the influx of refugees whose disadvantaged situation in society often leads to drug problems is described. The Dutch Government provides for a wide variety of services for drug users which include programs for minorities like the Surinamese, Moluccan, Moroccan, and Turkish communities. However, they are either executed poorly or are based too much on "White" methods. An account of a survey about the current situation of Black Surinamese women in the Netherlands is given, and the situation of refugees in the Netherlands as it relates to drug use is described. [Translations are provided in the International Abstracts Section of this issue.]

THE NETHERLANDS

The Netherlands (literally meaning the low lands) is a small, densely populated and highly developed country situated in Western Europe, adjacent to Belgium (in the South), Germany (in the East), and the North Sea. Politically speaking, the Netherlands is a constitutional monarchy with a parliamentary

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system. The seat of the government is in Den Haag (The Hague), and Amsterdam is the capital. The country has a total surface area of 41,548 square kilometers, 4,243 of which are uninhabitable as they consist of rivers, canals, and lakes. The country contains 15.4 million inhabitants, i.e., 452 inhabitants per square kilometer, which makes it one of the most densely populated countries in the world. The most densely populated area is the "Randstad" conurbation in the west of the country, which comprises the four main cities Amsterdam, Den Haag, Rotterdam, and Utrecht. Economically, the most important activities are commerce, shipping, and transit trade. The religious denominations are Roman Catholic (32%, mainly in the South), Protestant (22%, mainly in the North), Islamic (4%), Others (2%), and None (40%). More than half of the country lies below sea level, and the many dikes and pumping installations are therefore essential to keep the land dry (van de Wijngaart, 1991; CBS, 1995). Some claim that the constant threat from the sea, and the need to deal collectively with this common enemy, have led to a particularly well-developed sense of social responsibility among the Dutch (Engelsman, 1989).

The modern history of the country can be traced back to 1581, when it became an independent republic, the "Republic of the Seven United Netherlands," in which the most important part was "Holland." The Golden Age of the nation was the seventeenth century: The Dutch made a fortune trading around the world and continuously appropriated colonies. Being a prosperous and independent country, the Netherlands gained respect as a port of distress for political refugees from different parts of Europe.

NEWCOMERS IN THE NETHERLANDS

The character and demographic structure of Dutch society have undergone major changes over the years, the most radical shift taking place after World War II when people came from various parts of the world to settle in the Netherlands. Until World War II the Netherlands were a "white" country and one of the largest colonial powers in the world. Its colonies became independent fairly soon after the war ended. The indigenous people of the Dutch Indies fought for an independent Indonesia. Between 1948 and 1962, repatriation of 250,000–300,000 people from the Republic of Indonesia took place. These included a group of 12,500 Moluccans, most of whom had been soldiers of the Royal Netherlands Indies Army, who arrived in 1951. The Moluccan people lived on a group of islands in the Indonesian archipelago. Upon arrival in the Netherlands, the Moluccans were put into isolated camps near small towns because the Dutch government believed that after a short stay they would return to the Moluccan Isles. The people themselves also stayed strongly oriented toward a return to their homeland.

Surinam (South-American Dutch Guyana) and the Dutch Antilles (Aruba, Curaçao, Bonaire, St. Eustatius, Saba, St. Martin, situated in the Caribbean) had become equal partners with the Netherlands in 1954. Emigration from the former colonies has led to arrival of these ethnic minorities in the Netherlands. A relatively large influx of immigrants—people who had chosen the Netherlands as their new homeland—from Surinam arrived around 1975, the year of this country's political independence.

In the early 1960s when the economy in Western Europe was booming, large numbers of mainly unskilled male workers from Mediterranean countries came to the Netherlands, in the beginning mostly Spanish and Italian, later predominantly Turkish and Moroccan, but also of other nationalities like Yugoslavian. These laborers from abroad were called "guest-workers" because their stay in the Netherlands was considered to be temporary. Later, family reunification made it increasingly clear that this category had permanently settled in the new homeland. The immigration of foreign workers has gradually ceased. Today, they are being encouraged to retire in their country of origin with retention of their Dutch pensions (Ministry of Foreign Affairs, 1987; van de Wijngaart, 1988a; Niesing, 1993).

To a much lesser extent, the last few decades have also seen the arrival of refugees from various parts of the world, including Latin America and Asia. The Netherlands had thus become a multicultural society, and this has brought many far-reaching consequences in a wide number of areas. People who come from different cultures bring with them their own standards, norms, and values. Over the years a certain amount of integration has been established. The main problem has been to develop a certain amount of basic integration with retention of original cultural values. This is a process that requires adjusting from both the dominant culture and the new cultures.

The Surinamese community in the Netherlands is the largest with 263,000 members. Other communities with roots in past colonialism are the Antillean (91,000) and Moluccan (40,000). From the group of people who came to the Netherlands as foreign laborers, the Turkish community is the largest (241,000), followed by the Moroccan (196,000). (See Table 1.) It is noteworthy that among the 150 members of parliament, there are only six members from the cultural minorities. The number of people who are illegally staying in the Netherlands is unknown. According to government estimates, they range between 50,000 and 100,000 (Ministry of Justice, 1994).

Government minorities policy is directed at society as a whole but also distinguishes a number of specific target groups which are the particular focus of the objectives of integration and participation. Since the early 1980s these target groups, which have been selected on the basis of the position of social disadvantage in which they find themselves within Dutch society, have

Table 1.

Population in the Netherlands Divided into Relevant Different Cultures (as of January 1, 1992)[a]

	Whole country	In 4 largest cities: Amsterdam, Rotterdam, The Hague, Utrecht[b]
Surinamese	263,000	149,000
Turkish	241,000	90,000
Moroccan	196,000	94,000
Antillian	91,000	28,000
Italian	33,000	n.s.
Spanish	29,000	n.s.
Yougoslavian	27,000	10,000
Cape Verdians	14,000	12,000
Portugese	13,000	n.s.
Greek	10,000	n.s.
Tunesian	6,000	n.s.
Subtotal	921,733	n.s.
Chinese	40,000	n.s.
Vietnamese	10,000	n.s.
Others	1,392,000	n.s.
Total	2,364,383	n.s.
Moluccan	40,000	n.s.

[a]Sources: *Jaarboek Minderheden (Minorities Yearbook)*, 1995. *Statistisch Jaarboek (Statistical Yearbook)*, 1995.
[b]n.s. = not specified.

been defined as persons legally resident in the Netherlands and belonging to the following six categories (Minister of the Interior 1994):

- Greeks, Italians, people from (former) Yugoslavia, Cape Verdians, Moroccans, Portuguese, Spaniards, Tunisians, and Turks
- Suriname and Antilleans/Arubans
- Moluccans
- Refugees (44,000 with "permanent" status)
- Caravan dwellers (30,000)
- Gypsies (3,500)

The size of the target groups increased by 25% between 1987 and 1991. This growth is almost entirely due to the four largest groups: the Surinamese, Turks, Moroccans, and Antilleans/Arubans (CBS, 1995; Smeets et al., 1995).

Almost half of all members of ethnic minorities live in the four main cities. About 5% of the neighborhoods in Amsterdam, Rotterdam, The Hague, and

Utrecht accommodate 40% of all nonindigenous residents. Until the 1990s the four main cities still had no areas in which more than half of the population were people of non-Dutch origin. Now there are altogether six different neighborhoods where nonindigenous residents represent a majority of the population. In the early 1990s the government dropped the term "minorities policy" in favor of "integration policy." The term "integration policy" more clearly reflects the idea that the social integration of minority communities and their members is a process of mutual acceptance, requiring effort both on the part of the newcomers and on that of the society into which they are seeking to integrate themselves (Minister of the Interior, 1994, p. 8).

There has been a steady growth in the variety of services and products in the commercial sector. Members of ethnic minorities are gradually playing a role in the arts and the media, and the same trend can be seen in the health services, the police, and the schools. However, large sections of the minority communities still remain in a disadvantaged position. Unemployment among the cultural minorities is higher than among the native Dutch and the average net income is lower, mainly because laborers from the cultural minorities have jobs that require less schooling. (See Tables 2 and 3.)

In the present socioeconomic climate of recession and recovery, it is not an easy task for Dutch society to remedy this situation. Disadvantage remains in crucial areas, such as housing, education, and work. Women and young people are especially in danger of being marginalized. The position of Moroccan adolescents is relatively worst of all. This situation is exacerbated by signs of growing discrimination against ethnic minorities (Scheepers et al., 1996).

The position of people who stay illegally in the Netherlands is tragic. These people, estimated at 50,000–100,000, are officially unknown and not registered. Hence, they are not entitled to have a job or receive welfare and

Table 2.

People (age 15–65) Active in the Job Market (in %) (N = 6. 4 million in 1993)[a]

	Male	Female	Total
Turkish	59	24	43
Moroccan	52	14	35
Surinamese	66	46	56
Antillians	68	49	55
Native Dutch	76	47	62

[a]Sources: *Jaarboek Minderheden (Minorities Yearbook)*, 1995. *Statistisch Jaarboek (Statistical Yearbook)*, 1995.

Table 3.

Net Income per Month (in Dutch guilders; US$100 = ~ 150 guilders)[a]

	Turkish	Moroccan	Surinamese	Antillians	Dutch
<1,100	18	18	24	29	21
1,100–1,500	17	13	27	30	15
1,500–1,900	40	44	18	14	14
1,900–2,300	18	16	15	12	15
2,300–2,700	5	6	9	7	12
2,700–3,100	1	2	4	4	9
>3,100	1	1	2	4	14
Total % = 100					

[a]Sources: *Jaarboek Minderheden (Minorities Yearbook)*, 1995. *Statistisch Jaarboek (Statistical Yearbook)*, 1995.

other social benefits. As soon as an "illegal alien" has been detected, this person is sent back to his/her homeland, which is quite difficult if this person has lost the necessary identification documents. If necessary, these people are entitled to have urgent medical care, and minors have the right to go to school.

DRUG POLICY

At least three events have significantly contributed to the development of a drug policy that can be described as typically Dutch (van de Wijngaart, 1988a, 1990a, 1991).

The first one is the fact that the Dutch have been drug traders—not drug takers—for many years. The Netherlands has been trading large amounts of opium in the Far East for 350 years. In 1685 the amount of opium traded rose to over 100,000 kilos in a single year. The Dutch government controlled the supply and the distribution of opium in the former colony of the Dutch Indies (now Indonesia). At the end of the 1740s the first opium dens were established in the capital city of Batavia (now Jakarta). Opium users have been registered since 1908. According to official documents, the number of opium users on Java is 155,000, representing 0.5% of the 30 million inhabitants of the island. Ultimately, the Japanese invasion put an end to Dutch colonial opium practices in 1942 (Tan Tong Joe, 1929; Vanvught, 1985; van de Wijngaart, 1991).

In the early 1900s a Chinese community had been established in the two busiest Dutch ports. During the major harbor strikes of 1911 in Amsterdam and Rotterdam, Chinese sailors were hired in London as strikebreakers. The

number of Chinese workers grew rapidly into the thousands. They were employed to do unattractive work like stoking and trimming. When not at sea they lived in barracks in the shipyards where they could forget their sorrow and pain with the help of their opium pipe. The Dutch authorities turned a blind eye to their opium use. By 1914, the total number of Chinese had increased to 14,000 (van de Wijngaart, 1991; de Kort, 1994).

The second event is the history of cannabis use. Although the first Dutch drug law, the Opium Act, was enacted in 1919, the first signs of drug use of some significance appeared in the 1950s and concerned cannabis. The possession of cannabis was against the law, and the courts began to take action in the middle of the 1950s. Several citizens were sent to prison for periods of more than one year for the possession of marijuana. However, in the early 1960s and increasing number of young people started to smoke hashish and marijuana in spite of the legal consequences. Sentences of more than one year continued through the 1960s. Although criminal law had not played a part in preventing individual drug use, at the end of the 1960s a reconsideration of the prosecution policy was advocated by a growing number of experts and official agencies. They insisted on a decrease in punitive measures for the use of cannabis products, or for a deletion of these substances from the Opium Act. Their recommendations were based on the theory that protecting people from the danger of certain substances by means of punishment is an insufficient motive for interfering with a person's privacy. In 1976 a distinction was made in the law between "high-risk drugs" such as heroin and cocaine and the "traditional hemp products" hashish and marijuana. A major reason for this change was to prevent cannabis-smoking youngsters from entering the "hard drug" scene and sliding into the fringes of society (van de Wijngaart, 1988a; Jansen, 1994; Leuw, 1994).

The third important factor is the involvement of the drug user or addict him-/herself with the development of a humanitarian and pragmatic policy. In the early 1980s the "Junkiebond," a kind of union for drug users, was set up by a group of concerned heroin users. Their starting point was to look after the interests of the drug users. The "Junkiebond" claims that drug users deteriorate into "junkies" at a certain point, not because of the substance itself but because the drug is illicit. Through the years the "Junkiebond" had contributed significantly to the development of a policy aimed at the reduction of health risks and the improvement of the drug user's quality of life. It is noteworthy that a needle and syringe exchange was developed by the drug users themselves in the late 1970s, because AIDS showed up in the Netherlands. It should be added that selling syringes for any purpose is not against the law (van de Wijngaart, 1984, 1991:39–43; Dr. Use Good, 1992; Mainline, 1992).

HISTORY OF DRUG USE

As we have seen above, the first drug of significance was cannabis. At the end of the 1960s the number of cannabis users was estimated at 10,000–15,000 (Geerlings, 1970; van de Wijngaart, 1988a:484). Today the number of people who smoke hashish and marijuana is estimated at 675,000. The average last month prevalence of cannabis in a national sample of high school students (12–18 years) was 6.5% (de Zwart and Mensink, 1996). The use of cannabis is mainly recreational; the lifestyle of 0.1–0.2% cannabis smokers is so problematic that they consult the professional drug services (IVV, 1993, 1994).

Although opium was available on the black market, the number of users was limited to a few hundred in the early 1970s. Before 1972 the use of heroin was very limited. Although heroin was a desirable substance according to regular opium users, the supply was rather inconsistent and insufficient (Cohen, 1969; van de Wijngaart, 1988a:485). In the summer of 1972 heroin became available in large quantities at a relatively low price. People who previously injected opium, and those involved with amphetamines and LSD, were the first to switch to heroin (Epen, 1983; van de Wijngaart, 1988a:485). In 1972 heroin took over the Dutch opium market, and the number of heroin addicts increased sharply in the next 10 years. It was no longer middle-class youth who were experimenting with drugs; heroin use—and later heroin addiction—became a lower-class phenomenon. Two social developments contributed to this situation. First, the influx into large cities of immigrants with little schooling, and second, the international economic stagnation with large unemployment (13% of the labor force), the depopulation of the city centers, and the economic downturn of certain neighborhoods (van de Wijngaart, 1988c). Gradually the use of heroin was introduced in new groups. In the 1980s cocaine became a drug of preference for both heroin addicts and others. Today, the use of heroin by itself is seldom encountered. The vast majority of problematic drug users take a wide variety of drugs, including cocaine, tranquilizers, and alcohol. Today, the total number of "hard drug" addicts is estimated at 25,000 (i.e., 1.6 per 1,000 inhabitants), and more than 50% of them live in the four major cities (Factsheet, 1995; NIAD, 1995). Of those 25,000 drug addicts, 85% (N = 21,641) is in contact with the official drug user services. The number of addict-clients in methadone maintenance programs is 11,000 (IVV, 1996).

The percentage of drug addicts among the cultural minorities is much higher than in the general population. Drug addicts are between 0.1 and 0.2% of the general population, whereas they are possibly around 0.7% among the Turkish minority, 1.5% among Moroccans, 1.7% among Antillians, 2% among Surinamese, and 3% among Moluccans (IVV, 1994; NEVIV, 1995a).

Now and then new substances, both "artificial" and "natural," enter the Dutch drug markets. A present-day example of the former is XTC (ecstasy), the latter is khat (qat). It is noteworthy that qat has been introduced in the Netherlands by groups of refugees from Ethiopia and Somalia in East Africa. The possession of qat is not being prosecuted. The fresh plants are flown in from Kenya and Ethiopia and registered as "other fresh vegetables."

GOVERNMENT DRUG POLICY

In the last decade several studies by Dutch scholars have been published for an international audience (van Kalmthout, 1989; van de Wijngaart, 1991; Leuw and Haen Marshall, 1994; Korf, 1995). Moreover, scholars from abroad started studying drug policy in the Netherlands (Trebach, 1987; Nadelmann, 1988; Alexander, 1990; Goldstein, 1994). Finally, theory and practice have been debated from an American point of reference (Platt et al., 1990) and from a British perspective (Ghodse et al., 1990). However, there are hardly any systematic data available about drug use and drug addiction among cultural minorities. Neither does a clear policy exists with regard to cultural minorities and drug-use(r)-associated problems. This subject is even missing in the recent governmental document about drugs policy in the Netherlands (Ministry of Health, Welfare and Sports, 1995). Drug taking did not emerge as a growing social problem in the Netherlands until the 1970s. Initially the police and the judiciary dealt severely with drug users, but increasing doubts arose as to the value of criminal proceedings in such cases. These doubts and the growing significance of the problem led the government to appoint experts from various disciplines to form the Working Party on Drugs. The Working Party's recommendations, presented in 1972, have largely determined the direction of present-day drug policy.

> Following the recommendations of the Working Party, the government of the day saw no reason to base its policy on the idea that any use of the drugs concerned in itself represented an unacceptable risk to society. Whether or not such a risk existed would depend partly on the circumstances in which the drugs were used and the extend of their use. It was in the light of these factors that the prevention and control of the risks of drug use to society and individuals were made the primary objective of policy (Ministry of Health, Welfare and Sports, 1995:5).

Since that time, drug policy has had two main aspects: enforcement of the Opium Act and a policy of assistance to problematic drug users. The central objective has been to prevent and deal with the risks that drug use presents to

the drug users themselves, their immediate environment, and society as a whole.

As has been stated above, the amended Opium Act of 1976 separated hemp products from other "high risk" drugs. In addition, the possession of illicit drugs is subject to a less severe penalty than (inter)national trafficking. According to the Dutch government, the Act reflects the view that criminal law plays only a minor part in preventing individual drug use. Although the risks to society must be taken into account, every possible effort must be made to ensure that drug users are not caused more harm by criminal proceedings than by the use of the drug itself. The Dutch legal system takes into account the prevention and reduction of the individual, as well as the social risks involved in the use of drugs (Ministry of Welfare, Health and Cultural Affairs, 1985; van de Wijngaart, 1990:668). The drug policy of the government, however, is not only concerned with the detection and prosecution of punishable offences. On an individual level, assistance and prevention play a more important role. This is why the responsibility for coordinating drug policy lies with the Minister of Welfare and Public Health in particular (Wever, 1994). In the Netherlands the Ministry of Welfare and Public Health has developed its drug policy in close cooperation with the Ministry of Justice. The (mis)use of (illegal) drugs is basically seen as a matter of social well-being and public health (a task for the Ministry of Welfare and Public Health), and of trafficking and drug-related criminality as law enforcement problems (a task for the Ministry of Justice). Both ministries acknowledge that drug laws and its enforcement are meant to reduce the supply of drugs, not to criminalize use of drugs.

The first government policy document specifically focusing on aid to drug addicts appeared in 1977. Since then the national government has formulated a number of points of reference and policy principles, including:

1. Drug use must get rid of its taboo image and its sensational overtones. Drug users must be treated, as much as possible, as "normal" people who are given "normal" opportunities and of whom "normal" demands are made (i.e., the normalization of drug problems).
2. Drug users must not be approached as criminals, nor as dependent, helpless patients.
3. The importance of a "low-threshold" (ease of access), multifunctional network of medical and social services at a local or regional level to provide assistance for particular problems.
4. The efficient use of nonspecialist facilities that can provide assistance to problematic drug users, such as primary health care facilities including general practitioners, and youth welfare facilities.
5. The promotion of social rehabilitation of (former) problematic drug users.
6. The importance of preventive action: the "risks" of drug use should be put

across as part of a general health education campaign rather than as a separate issue.

7. Policy is increasingly directed toward drugs in a broad sense, i.e., including alcohol and nicotine/smoking (van de Wijngaart, 1991:33–34).

LOCAL DRUG POLICY

The main task of the national authorities is creating conditions and stimulating activities to minimize the "risks" of drug use for individual drug users, their immediate environment, as well as for society at large. The local authorities, however, are confronted with divergent interests. In the cities, public order—the prevention of nuisances caused by drug users and their "environment," such as street pollution, street prostitution, and crimes against property—has gradually become the major issue in constituting local drug policy. Local drug policy influenced national drug policy (Ministry of Health, Welfare and Sports, 1995:19–25).

By the early 1980s the drug problem had assumed greater proportions, including a steady growth among ethnic minority youth, the spread of drug-use(r)-associated problems into the countryside, and an increase in crime and public order problems in the major cities. The city authorities asked for measures to facilitate the access of problematic drug users into the treatment system. They should enter treatment either voluntary or under compulsion. The compulsion option was dropped later and replaced by "treatment under pressure," in which drugs addicts who are repeatedly arrested for offenses may choose either to serve their entire sentence or opt for treatment. In discussion with the city authorities, the accessibility of the drug-user services was identified as the central problem. Most services were only willing to help addicts who wanted to "kick their habit." Consequently, the improvement of the accessibility of the services to drug addicts became a fundamental objective of the policy; drug-user services should be brought in line with local needs and respond adequately. Through the rapid introduction of a nationwide network of methadone maintenance programs and by starting new services such as walk-in centers (i.e., community centers for street addicts, where food, clothes, medical care, and social work services are available) and outreach work, through which street addicts are brought into contact with services, services had to become more accessible ("low-threshold"). The government was in the position to direct this policy by providing substantial additional funding.

In urban areas it is possible to adjust local drug policy to the specific needs and demands in that region, e.g., the second and third generation Surinamese and Mediterreneans (Moroccans, Turks). In the 1990s a growing number of welfare projects for immigrants has been initiated. It is the author's opinion that

these projects for immigrants are often not well-prepared, too fragmented, and poorly evaluated. However, other innovative experiments have also been developed, such as the "methadone busses" in major cities, an important feature in the Dutch public health model of methadone maintenance *care*. Methadone busses serve as mobile methadone posts where methadone is dispensed to registered addict-clients (van de Wijngaart, 1988b; Ball et al., 1994; Plomp et al., 1996). Other innovations are maintenance programs with morphine (Amsterdam) or injectable methadone (Amsterdam, Rotterdam) and vending machines or dispensers for syringe exchange (van de Wijngaart, 1990c, 1990d).

TREATMENT AND CARE IN A HISTORIAL PERSPECTIVE

The first initiatives to help people with addiction-associated problems emerged at the end of the nineteenth century. Initially, fighting alcohol use with curative purposes in mind was fostered by the Workers' prohibitionist organization. In 1891 a small *sanitorium* for "dipsomaniacs" named Hoog-Hullen was opened in the Northern part of the country. In Amsterdam the first outpatient clinic for alcoholics was established in 1909. More organized services to people with alcohol-use-associated problems developed in the 1920s and 1930s. This type of aid acquired an additional function in the area of rehabilitation, as these clients often have brushes with the law. A network of Consultation Bureaus of Alcohol developed after World War II between 1948 and 1953 and added "Drugs" to their name (CAD—Consultation Bureau for Alcohol and Drugs) in 1969 (van der Stel, 1995).

In the beginning there was little knowledge how to handle and treat problematic drug users. The Consultation Bureaus for Alcohol and Drugs (CADs) developed "high threshold" programs, and abstinence was the only aim. "Once an addict, always an addict" was a common consensus in the early 1970s. In 1968 a small methadone maintenance program was opened in Amsterdam (Jellinek Centre), and before long also in The Hague. In 1972–1973 methadone was given to 450 heroin addicts in Amsterdam (Fromberg, 1974; Geerlings, 1970, 1975, 1976; van de Wijngaart, 1988b).

In 1972 the first therapeutic community for drug addicts, the "Emiliehoeve," a department of a psychiatric hospital near The Hague, was established. In the beginning the Maxwell Jones model was applied. However, the need for (more) structure for the clients was soon felt and consequently more structure was introduced. The expectations were high. The methadone program in The Hague was converted into a detoxification program, and most of the clients who went to the Emiliehoeve finished the program. The success of the Emiliehoeve resulted in a change in treatment of some other therapeutic communities. A hierarchical structure was introduced: about 10 therapeu-

tic communities for drug addicts were in service in the second part of the 1970s and still are. However, the tight, hierarchical approach of these new TCs was only appropriate for a small group of drug users. The centers, which operated on a basis of strict rules, only partially fit in the tolerant and liberal attitude toward drug users in the Netherlands. Other treatment centers had to develop different treatment programs (Kooyman, 1992:5–11). The expectations of the politicians and policymakers that treatment of drug addicts could solve "the drug problem" turned out to be an illusion. They concluded that very few addicts were eligible for the traditional abstinence-oriented forms of treatment. Furthermore, a growing number of complaints arose from the cities that drug addicts were a major cause of all kinds of public order problems. In the late 1970s, when drug-use(r)-associated problems increased rapidly, socially oriented care programs developed as a reaction to the existing services where were considered too medical and too psychiatric.

A new treatment philosophy emerged, grounded in private initiatives and in concern for the social disadvantages of most drug addicts. The socially oriented drug care aimed at the minimization of drug-use-related harm by accepting the addict and the addict's drug use, and attempting to reduce the individual and social "risks" of drug use. The aim of these forms of care was to improve the physical and social functioning of problematic drug users, without necessarily ending their drug use. In the cities, experimental projects were opened where "hard drug" users could meet and relax. It turned out that drug users, especially the Surinamese, felt comfortable in the relaxed atmosphere of these projects. There was a fast expansion of a diversity of projects, but without much coordination and planning. A lot of these projects were badly organized and failed sooner or later because of mismanagement, a symbiotic attitude of the professionals toward their clients and the presence of drug dealers in the projects. Moreover, there was a strong call from the local population for police intervention. All those experimental projects gradually closed down.

After a period of reflection, with the support of local and national authorities, an array of services has been created, ranging from street-corner work, accessible low threshold (day) centers, methadone maintenance programs, and social assistance to educational and job-training projects. The keyword in the period 1975–1985 was "increase" and "more of the same." First of all, increase funding and increase the number of treatment facilities. For example, the funding for the CADs rose from 16.0 million guilders in 1975, through 44.5 million guilders in 1980, to 65.4 million guilders in 1984 (WVC, 1985). Subsequently, an increase in variety of approaches, in treatment personnel, in policy makers, but—against all expectations—also an increase in the number of drug addicts. Since improving the physical and social conditions of problematic drug users became the short-term goal, with abstinence as a long-term

goal, the drug-user-treatment services had to change their "ideological" orientation as well. Early doubts about the ethical implications of methadone maintenance treatment made way to the view that methadone was an essential instrument, although it should be offered in combination with at least some form of counseling.

In the 1980s the differences in approach between the social welfare programs and the treatment programs became less distinct. The CADs also started easy access, low threshold methadone maintenance programs aimed at the reduction of medical and social "risks" connected to drug sue. Additional drug use was more and more accepted, and the influence of the clients themselves on the programs was growing.

Addiction services were improved during the 1980s by professionalization, improvement of diagnostic methods, application of psychotherapy and a variety of forms of assistance, and different kinds of harm reduction activities and projects. Special programs for pregnant drug-addicted women, children of addicted parents, drug-addicted prostitutes, and women with AIDS have been developed, as well as "buddy" help and central municipal case management for drug addicts with HIV infection.

The number of "hard drug" addicts has grown slowly during the past 10 years (estimated 5,000 in 1977, 15,000–20,000 in 1985, 25,000 in 1995; Ministry of Welfare, Health and Cultural Affairs, 1985; Ministry of Health, Welfare and Sport, 1995). The types of problems within this population have significantly changed. Mental disorders, psychiatric problems, and the misuse of cocaine and prescribed drugs like tranquilizers and sleeping pills are important issues that influenced drug policy and treatment services.

With the rising problem of HIV infection and AIDS among drug users, reducing needle sharing and unsafe sex as major causes of contamination became major targets. The policy was and is very pragmatic. The needle and syringe exchange programs in Amsterdam were initiated in 1984 by the "Junkiebond." No increase in drug use could be validated, participants of the exchange schemes were less involved in needle sharing, and there was no increase in needle stick accidents among the general public. The incidence of Hepatitis B decreased.

On April 1, 1992, the cumulative total of AIDS cases was 2,076, of which 9% were intravenous drug users. It is estimated that almost half the number of registered patients have died. On the basis of pilot studies it is estimated that 30% of the intravenous drug users in Amsterdam is seropositive; in the rest of the country these estimates are lower (from 25 to 5% of IV users in the countryside). It is noteworthy that testing for HIV only occurs on a voluntary basis.

ACTUAL HEALTH CARE AND DRUG TREATMENT SYSTEM

The Netherlands was a health care system which is easy of access to each and every inhabitant. The government is responsible for providing the necessary legal framework and the promotion of the facilities for preventing diseases and accidents, as well as providing treatment and care of those with limited means.

The actual addiction care and treatment system consists of a varied and coordinated network of services, in both geographical and methodological terms. The services are equipped for a variety of addictions, such as alcohol, other drugs, and gambling. All these services are only accessible on a voluntary basis. The care for addicts consists of a wide range of harm reduction services and (drug-free) treatment facilities, forming multifunctional networks of medical and social aid on a local level, geared to the local problems and needs, and thus varying from town to town.

Today, the CAD network consists of 16 main centers with 104 branches spread over the country. The total number of staff is around 1,400, of which 950 are in actual counseling. The percentage of employees from the cultural minorities is not registered, but probably lower than 5%. The total budget for 1991 amounted to 80 million guilders. The staff consisted mainly of social workers and nurses who work in cooperation with psychologists, physicians, and psychiatrists. CADs cover areas which, to a large extent, coincide with the jurisdiction of Dutch Courts. This is due to the close organizational ties with the judiciary in the past. The task of the CADs includes prevention, (methadone maintenance) care, treatment, and rehabilitation. The CADs also have a probation task; one of its aspects is the initial reception of drug addicts in police stations (where an effort is made to establish contact that may lead to the acceptance of further assistance during and after detection), another aspect is the writing of probation reports for the courts.

A variety of methods is used, including psychotherapy, group therapy, family therapy, acupuncture, counseling, social assistance, and partner and parent groups. An increasingly important area of the CADs work is prevention, including the field of AIDS—needle exchange, supply of condoms, health education in general, and "safe sex" and "safe use" information in particular. In addition to the CADs, several municipal and regional health services run methadone programs that are involved in health and drug education activities, needle exchange, and condom supply.

In 1995, the NEVIV—the national umbrella organization of CADs and other drug-user-relief organizations—conducted a survey among their 40 member institutions in order to gain insight in the state of affairs in the development of a "multicultural" care and treatment system. The results of the study,

which had a 90% response, were far from promising. Only 13 out of 40 institutions had yet developed an explicit policy toward cultural minorities. Nine institutions had appointed a "minorities" expert (NEVIV, 1995b).

In 1993 the CADs registered 54,171 clients, of which 25,278 were new clients. Of those, 41% came for drug-use-related problems (mainly heroin and polydrug problems), 40% for alcohol-use-related problems, and 12% for gambling problems. Of the drug clients, 75–80% are men. Methadone was supplied to 8,698 different clients.

Through the years the population of drug clients has grown older and the mean age has risen. Of the 1992 clients, 11% was under 21 years of age, 20% was 21–24 years old, 25% was 25–29, 22% was 30–34, 13% was 35–39, and the remaining 9% was 40 years and above.

There is hardly any data available with regard to the use of services by members from the cultural minorities. The only data available concern the year 1993 (Table 4). These data show that there are relatively high representations among drug clients from Moroccan, Surinamese, and Antillian descent as well as Moluccans. Relatively highly represented among clients with gambling problems are people of Turkish and Moroccan descent (IVV, 1994).

The "low threshold" welfare projects for drug users are part of a wide range of social welfare services for young people, primarily aimed at prevention and/or risk reduction: street-corner work; social assistance; day and night centers with psychosocial assistance; learning, working, and housing projects; resocialization projects; and projects specially aimed at specific groups like Moroccan youth. In 45 municipalities there are almost 90 projects. These

Table 4.

Cultural Background of New Clients in 1993[a,b]

	Alcohol	Drugs	Gambling	% Total population
Turkish	0.8	1.4	3.4	1.6
Moroccan	0.8	3.3	2.3	1.3
Surinamese	1.3	7.4	2.2	1.7
Antillian	0.7	2.4	0.7	0.6
Moluccan	0.2	1.2	0.7	0.3
Other	4.4	8.8	5.2	
Unknown	3.2	7.1	2.5	
Dutch	88.6	68.4	83.0	>90

[a]No accurate figures are available as regards the cultural background of the whole addict population. However, it is estimated that more than half of the population is of non-Dutch origin. This is especially true in the main cities.

[b]Source: IVV, *LADIS 1993*.

projects, which employ around 500 professionals, have a total budget of 55 million guilders, financed by the government. *Blaka Watra*, which is part of the interchurch Rainbow Foundation, is an example of a "low threshold" welfare project in Amsterdam with an average number of 30 visitors per day. Their target group consists of elderly (>age 40) Surinamese and Antillian drug users who have become socially isolated.

There are 20 inpatient, (mostly) drug-free clinics located throughout the country. There is a wide range of facilities: crisis-detoxification clinics, short-term and long-term drug-free treatment clinics, therapeutic communities, daytime clinics, and polyclinic services. Together, they have a capacity of 1000 "beds." The yearly costs amount to 100 million guilders and are funded by contributions under the Exceptional Medical Expenses Act, which is part of the public health insurance system. Some clinics have specialized in alcohol-user treatment, others in drug-user treatment. However, more and more facilities are open to people with all kinds of addictions, including addiction to pills (benzodiazepines) and gambling. A variety of methods is used, including individual and group psychotherapy, family therapy, encounter groups, and relapse prevention. Aftercare and resocialization is realized in cooperation with the CADs.

These inpatient facilities may take the form of an independent clinic or be related to a CAD (11 of 20) or be a special unit in a general psychiatric hospital (9 of 20). Since the second part of the 1980s initiatives have been taken to set up multifunctional addiction treatment centers with residential as well as outpatient services. Until today it has not been possible to create inpatient facilities and programs where members from cultural minorities fit in. The adopted/applied therapeutic approaches and methods are predominantly "white" methods. Addicts of non-Dutch origin feel strange in these programs and usually quit after a couple of days. The Jellinek Center in Amsterdam has created a 12-weeks inpatient program for cultural minorities called IMC, the Intercultural Motivation Center. Between 16 and 18 male clients participate in a program where the main aim is to step aside from the world of drug use. It is a period of cleaning up, reflection, and making plans for the future. Although some of the clients progress into an inpatient treatment center after 12 weeks, they do not fit in (Ligeon et al., 1990; van de Wijngaart, 1990a; Campbell and Pinas, 1996).

This whole relief system is financed through the government, and admission and services are free. However, the political agenda in relation to the addiction services is dominated by financial and organizational questions. Issues for the near future are a more differentiated approach, a more coherent treatment system, and the implementation and evaluation of higher quality standards.

Since the late 1970s the number of "self-help" groups have arisen. These include Alcoholics Anonymous, Al Anon, Alateen, Narcotics Anonymous, Gamblers Anonymous, Parents of Drug Addicts, Overeaters Anonymous, and groups for women with Anorexia Nervosa and Benzodiazepine/Medicine Addiction. In the 1980s health care professionals and therapists usually looked down on these "self-help" groups. Today, the climate has changed and cooperation is gradually growing. CADs and inpatient facilities often refer clients to "self-help" groups. Finally, there are organizations of volunteers who offer different forms of professional treatment and care such as those dealing with addicted parents and their children. The national Foundation of Parents of Drug Addicts, consisting of many local groups, plays an important role. In several ciites groups of organized drug users, the so-called "Junkiebond," are active in the field of health education and prevention. They promote the interests of drug users and counsel their "fellow" addicts. At times, the Surinamese "Junkiebond" is active in Amsterdam.

DRUG USERS IN PRISON

There are 19 houses of (pretrial) detention and 17 prisons in the Netherlands. Opiate addicts who had committed crimes to finance their opiate consumption were first seen in Dutch prisons in the early 1970s. The increase in the consumption of illicit drugs since 1972 has led to a rise in drug-related crime and consequently in the number of addicts in prison (Brand-Koolen, 1987). We agree with Rüter (1986) that one of the main unintentional effects of the use of criminal law to combat drugs has been the considerable growth of persons with drug-related problems, such as dealing and trafficking within the Dutch penitentiary system.

The number of addicted inmates increased steadily from 259 in 1971 to 1,036 in 1975, 2,167 in 1979, and 5,500 in 1987. In 1980, 23% of the prison population was estimated to be drug users, In 1984, they were 27% of all prisoners. In 1993 the percentage of drug users of all 8,037 inmates was estimated at 50 to 70%. These estimates are based on self-reports and/or needle mark inspection by correctional medical personnel. A considerable number of Dutch detainees (30%) originated from Surinam or the Dutch Antilles (van de Wijngaart, 1991; Erkelens et al., 1994). The percentage of inmates with a non-Dutch nationality—the majority being drug traffickers—is gradually rising and in 1993 was up to 48% (CBS, 1995; Smeets et al., 1995). (See Table 5.)

Prison physicians have professional autonomy. There are no rules or regulations obliging physicians to treat detainees differently from the way they would treat them outside the prison walls. However, physicians do not agree

Table 5.

Nationality of Detainees in Percentages (1993)[a]

Europe:		64
Netherlands	52	
Germany	1	
Turkey	6	
Other	5	
Africa:		11
Morocco	8	
Other	3	
Asia:		4
Middle East	2	
Other	2	
South America:		19
Surinam	11	
Dutch Antilles	6	
Other	2	
Other American		1
Other/unknown		1

[a]Sources: *Jaarboek Minderheden (Minorities Yearbook)*, 1995. *Statistisch Jaarboek (Statistical Yearbook)*, 1995.

unanimously upon the desirability of having methadone maintenance and needle exchange inside the prison.

In the Dutch prison system there are 13 different sections with a total of 330 cells where drug addicts follow a special program to prepare these inmates for possible drug-free treatment in a specialized clinic. About 50 CAD probation officers work in the prison system in these drug-free sections. The CAD probation service is cooperating more and more with the criminal justice system in special projects for prosecuted addicts.

SURINAMESE WOMEN AND "HARD DRUGS:" AN EXPLORATIVE STUDY

In the Netherlands, scientific data about drug users in general and drug addicts in particular is limited. Relatively, most is known about the lifestyles of White male drug users. Due to ethnocentrism and sexism in policy and science, less is known about Black males and White females. Hardly anything is known about the lives of Black female drug users. In order to change that situation, the Surinamese drug and welfare organization in the Netherlands

(SDOS) has commissioned us to explore and describe the current situation of Black (Surinamese) women in the Netherlands. The results of such a survey could contribute to a better understanding of the "meaning" of drug use, less "labeling" and discrimination, and a well-balanced emancipation policy.

In the first phase of the (low-budget) survey we have studied the general literature about the arrival, the socioeconomic situation, and the health of Surinamese people in the Netherlands. In consultation with the SDOS, we proposed the following four central issues:

1. Immigration into the Netherlands. In which period, with which motives, and with whom did Surinamese women come to the Netherlands?
2. Socioeconomic status. What is the social position of the women before the onset of drug use, either in Suriname or in the Netherlands?
3. "Hard-drug" use. How did the women come in contact with illegal drugs, which drugs are being used, how and in what ways is the habit financed, and what is the present socioeconomic status of the women?
4. Problems, needs, and assistance. Does the use of illegal drugs lead to addiction or other problems, what are the specific needs of the women, are the drug-user treatment and guidance facilities well-equipped for these needs, and are there specific gaps in the assistance program?

We started with the search for and further analysis of relevant literature. First, more general studies into the position of Surinamese man and women in the Netherlands. Next, more specific literature about Surinamese women and health (care). Subsequently, we screened the available documents on drug use in the Netherlands. Finally, we studied the literature on the position of Black female drug addicts in the United States.

On the basis of this literature, a questionnaire was developed. First, 13 counselors and social workers (preferably Surinamese) who work in drug-user institutions were interviewed about their views and knowledge and their own experiences in the field with Surinamese women. Subsequently, two female field-researchers (one Surinamese, one Dutch) conducted in-depth interviews with 12 Surinamese female drug users. These women were reached through the mediation of the helping professionals and by means of independent field work. Assistance by the media (radio, Surinamese weekly newpaper) was not successful. The results of the study follow.

The immigration of Surinamese into the Netherlands has fluctuated through the years. In the 1950s and 1960s a relatively small group of predominantly middle-class immigrants with a solid educational and vocational background decided to leave Suriname for further education. In the period 1968–1975, lower class immigrants moved to the Netherlands, mainly for socioeconomic reasons, i.e., social services, income, and employment were better in the Neth-

erlands. The Surinamese family system is predominantly matrifocal; the role of women can be described as "extended motherhood." In the Netherlands, unemployment figures, housing problems, and level of education are worse for Surinamese than for native Dutch.

There are an estimated 5,000 drug addicts of Surinamese descent in the Netherlands. In the city of Amsterdam around 12.5% of the Surinamese drug addicts are female, which is relatively less than the percentage of women (25–30%) in the addict population in general. Literature about drug use in the Netherlands offers hardly any insight into the background of female Surinamese "hard-drug" users, but (little) more is known about the situation of the male population. Drug addiction has been explained in terms of the weak socio-economic status of certain groups of Surinamese immigrants. It was quite impossible for them to enter the highly structured and inflexible Dutch job market. Instead, they continued the "free-trade" street culture ("hosselen") that is practised in Surinam. In the Netherlands this "gray" circuit is very well suited for drug dealing, receiving, and other (petty) crimes. In this way numerous Surinamese men came in contact with the heroin "scene." Other factors that have contributed to this dramatic change are religious and cultural gaps, as well as the disappearance of social control because of the gradual weakening of the Surinamese family structure. Our interviewees were all born into Creole families in Surinam and came to the Netherlands in the years 1968–1978. Some of these were still young (age 6–16) when they left with their mothers and other relatives. The other women were already adults when they left for the Netherlands. Some of these had children which they left behind (temporarily) in Surinam. They had problems adjusting to the new culture. They did not like the climate, the food, and the housing. They had problems understanding the everyday language and often felt homesick. The younger women did not experience these problems of acculturation, but were still not able or willing to finish school.

Some of the women had made the acquaintance with cannabis in Surinam, but they had not used it regularly there. These women started to take illegal drugs for the first time in the Netherlands, unaware of the effects and consequences of drug use. They were initiated into the habit by their (addicted) boyfriends or partner because of curiosity and/or wanting to "feel what he felt." Heroin was the first "hard drug" they used, later followed by cocaine. Surinamese women usually take these substances by smoking or "chasing the dragon." Only one of the women told us that she injects drugs. All of the women have experience with methadone; the older ones have taken benzodiazepines as well.

All the women receive a social security benefit, but this money is not sufficient. The majority of them enjoy extra income from (street) prostitution

and/or offences like shoplifting and check fraud. Some of them deliver drug-related "services" like packing and carrying and being on the lookout. A small minority live the life of a housewife, getting the drugs from their partner. All women have experienced variable periods of abstinence from illicit drugs; for instance, during holidays in Surinam. The majority of the women have one or more children. The treatment facilities in the Netherlands are not adapted to the needs of women from abroad. In general, Surinamese drug users are not very much attracted by methadone and methadone programs. Since methadone is prescribed by a physician, the women think of methadone as a medicine. However, methadone is not a remedy that can really cure. Moreover, it is hard to quit the methadone habit. The drug-free inpatient clinics or therapeutic communities apply methods that have been developed with White men or women. Surinamese women feel very strange in such an environment—it is too verbal—and they usually leave after a couple of days. Moreover, both inpatient and outpatient programs usually lack care facilities for the children of these women. The women have a preference for consulting female counselors (not necessarely Surinamese counselors), but notice that there are not enough of them. They want the counselor to be their friend or at least act like a friend. Finally, refresher courses and facilities for vacational training are too few or inappropriate.

REFUGEES

During the last ten years the number of refugees seeking asylum in the Netherlands has gradually risen: from 5,600 in 1985, through 21,200 in 1990, to 35,400 in 1993 (CBS, 1995:428). The number of refugees in Europe was estimated as 930,000 in 1991 (Hulshof et al., 1992:65). However, the rules and regulations covering permission to stay in one of the countries of the European Community (EC) have become more strict. Two seemingly inviolable basic principles related to the Status of Refugee which were maintained until recently by, among others, all West European States, applied to all people who appealed to the 1951 Geneva Convention (Meijers et al., 1993):

1. Every asylum seeker who claims to be a refugee has free access to a thorough procedure in which this claim is examined in order to consider if it is well-founded.
2. If the claim is considered well-founded, the State concerned grants the refugee asylum unless he or she is assured of adequate protection by another State.

The 1992 London Rules on Immigration, however, imply that both basic principles should be abolished. On the basis of the London standards, no state

will have to expand its protection of "aliens" or increase its admission of foreigners who want to reunite with their families. In reality, the opposite is the case. The London standards have resulted in fundamentally restricting admission and legal protection of non-Western European citizens (Fernhout and Meijers, 1993).

After a person from outside the EC has applied for asylum in the Netherlands, the Minister of Justice can make either of four decisions (Smeets et al., 1995):

1. The request is granted and the person receives an A-status (length of stay unlimited).
2. The request is declined, but the person involved receives a permit to stay on humanitarian grounds.
3. The request is declined, but the person involved may stay for a certain period of time until the conditions in the country of origin make a safe return possible.
4. The request is declined and the person has to leave the Netherlands.

In 1993, 35,400 requests were made to stay in the Netherlands; 15,800 requests were permanently declined and 10,300 requests resulted in an A-status. The others are still waiting or have made a second request (appeal) (CBS, 1995). The use of drugs or addiction problems have never been an obstacle to entering the country.

In the first period of their stay, refugees usually stay in special facilities before they find a more permanent place to live. Many refugees have suffered traumatic experiences, often a combination of extreme powerlessness and agony. They are usually victims of organized terror and might have experienced stressors such as broken families, death of relatives and "significant others," repression, violence, torture, rape, and inprisonment. These stressors have forced them to leave their homeland and become strangers in a new safe haven. They might experience different kinds of exile problems such as disruption, feeling uprooted, anger, grief, uncertain future, social and economic problems, homesickness, isolation, loneliness, and discrimination. The interaction of all those factors has been considered to facilitate the development of substance use and addictions significantly.

Refugees from East African countries like Somalia have a habit of chewing qat. This habit used to be "ritualized," embedded in their traditional life and culture. In their new haven these rituals are absent and thus social control is lacking. Khat and later other substances such as alcohol become "remedies" in trying to alleviate pain and sorrow. Benzodiazepines are taken to relax to induce sleep. In this way a vicious circle might develop, and addiction problems are likely to develop. To prevent those developments as much

as possible, the CADs and refugee organizations have set up special courses for nurses, social workers, and volunteers who work with refugees.

SUMMARY AND CONCLUSION

The Netherlands is a densely populated country whose main economic activities are commerce, shipping, and transit trade. In the Dutch golden age in the seventeenth century, the Dutch made a fortune trading around the world and continuously appropriated colonies.

Due to the independence of Dutch colonies after World War II, people came to settle in the Netherlands. The first group of people was repatriated from the Republic of Indonesia; it included some Moluccans. A second group were immigrants from Surinam and the Dutch Antilles. A third group arrived in the early 1960s when unskilled male workers from Mediterranean countries came to the Netherlands to work as "guest-workers." This category later settled permanently in the Netherlands. Refugees from various parts of the world form the fourth group of settlers. The Surinamese community is the largest, followed by the Antillean and Moluccan communities. Of the group who came as foreign laborers, the Turkish community is the largest, followed by the Moroccan community.

The governments minorities policy distinguishes specific target groups which have been selected on the basis of social disadvantage in Dutch society. Large sections of the minority communities remain in a disadvantaged position. The position of Moroccan adolescents is worst of all. The people who remain illegally in the Netherlands are not entitled to any social services. However, urgent medical help and education for minors is available.

Three elements have contributed to the development of a "typical Dutch" drug policy. The fact that the Dutch have been drug (opium) traders—not takers—in the Far East for 350 years. A second event is the history of cannabis use which led to the legal distinction between "high-risk" drugs, such as heroin and cocaine, and hemp products. The third important factor is the organization of drug users in a union, the "Junkiebond," aimed at the reduction of health risks and the improvement of the drug users quality of life.

The history of Dutch drug use can be described by the following stages. The first drug of significance was cannabis, and it is now used mainly recreationally. When heroin became available in 1972, the number of heroin addicts increased sharply, especially among immigrants. In the 1980s cocaine became the drug of preference. Today the vast majority of problem drug users take a wide variety of drugs including cocaine, alcohol, and tranquilizers. The percentage of drug addicts among cultural minorities is much higher than in the general population. New substances have entered the drug market, e.g.,

XTC and qat (khat), the latter introduced by refugees from East Africa. There are hardly any data available about drug use among the cultural minorities nor does a clear policy exist toward cultural minorities and drug-use(r)-associated problems.

Government drug policy is based on the prevention and control of risks of drug use to society and to individuals, which means enforcement of the Opium Act on one hand and a policy of assistance to problem drug users on the other.

The major issues in local drug policies are prevention of the nuisance caused by drug users and the accessibility of services to drug addicts. In urban areas it is possible to adjust the local drug policy to the specific needs and demands in that region.

The first initiative to help people with addiction problems was directed at "alcohol abuse." A network of consultation bureaus for alcohol-use-associated problems was established after World War II; these bureaus now play a role in their service to drug users. Various methods and services were established, and programs were developed and sometimes abandoned for various reasons. Noteworthy are the methadone maintenance programs which started in 1968 and the needle and syringe exchange programs.

The actual addiction care and treatment system consists of a varied and coordinated network of services in both geographical and methodological terms. The services are equipped for a variety of addictions, such as alcohol, other drugs, and gambling, and consists of a wide range of harm reduction services and (drug-free) treatment facilities geared to the local situation and varying from town to town.

In 1995 a survey was conducted into the state of development of a multicultural care and treatment system. The results of the study, which had a 90% response, were far from promising. Very few local services had developed an explicit policy toward cultural minorities. The therapeutical approaches and methods used are predominantly "white" methods.

Since the late 1970s the number of "self-help" groups has risen, and the union of drug users (the "Junkiebond") offers health education, prevention, and counseling. This entire relief system is government financed.

The increase in the consumption of drugs has lead to a rise in drug-user-related crime and consequently to the number of addicts in prison. The percentage of inmates with a non-Dutch nationality—the majority are drug traffickers—is gradually rising. Access to services in prison is possible. However, there is not as wide a range of services as there is outside of prison.

In the Netherlands, scientific data about drug addicts and drug users are limited. Even less data are available about Black males and White females. For that reason a survey on the current situation of Black (Surinamese) women in

the Netherlands was commissioned. One conclusion was that Surinamese drug users are not attracted by services such as methadone maintenance treatment or the methods used in the therapeutic communities since the methods used there are merely "white." In addition, most Surinamese female drug users have children and the Dutch programs lack facilities for children. Surinamese female drug users feel most comfortable with female counselors, but there are not enough of them.

During the last ten years the number of refugees seeking asylum in the Netherlands has gradually risen. Many refugees have suffered in their country of origin and often experience exile-associated problems. The interaction of these stressors is thought to facilitate the development of addictions significantly, in addition to which substances such as qat, alcohol, and benzodiazepines can become "remedies" in trying to alleviate pain and sorrow or insomnia. Special courses to prevent addiction problems have been set up to train people who work with refugees.

The author agrees with Draper (1987) that it is hardly possible to isolate drug policy from foreign, economic, and social policy. He concludes that while good social policy is not a panacea for drug-use(r)-associated problems, improvement in housing and employment can contribute to their solution. More (quantitative) research is needed in the Netherlands to understand drug use among cultural minorities, contemporary knowledge about drugs and drug use, and the prevalence of drug-use(r)-associated problems. The same goes for alcohol, about which even less is known. Primary prevention and harm reduction can only be effective when these data are available. Education and planned interventions should be established in consultation and cooperation with key persons in the communities. Those activities could bridge the gap between (individuals in) the communities, the social services, and the care and treatment system. The author agrees with Sue and Zane (1987) that an important explanation for the problems within the treatment system lies in the inability of social workers, counselors, and therapists to offer sensitive, culturally suitable or "matched" forms of guidance and treatment. Those professionals do not have sufficient knowledge and an affinity for the diverse cultural backgrounds and lifestyles in the different minorities.

The following changes will be needed to alter that situation for the better. More professionals are needed who are bilingual and have thorough insight into different cultural values and life-styles. More professionals are needed who themselves have roots in different cultural minorities. The prevailing methods of counseling and treatment should be adjusted and expanded to the needs of clients from the cultural minorities. To implement these priorities, the reallocation of funding is inevitable. However, nowhere is the discrepancy between good intentions and actual consequences greater than in the field of drug

policy. Since substances such as heroin and cocaine are categorized as illicit drugs, the ways to contain drug use and its consequences are limited. The law distorts substance misuse, and the drug user is stigmatized as deviant or criminal. Although the possession of those drugs is forbidden, they are quite easy to obtain, not only in the Netherlands but everywhere else in the world too. Dealing illicit drugs often looks like a change for the better. However, it is a dead-end street that only leads to further marginalization. It is another main effect of the use of criminal law to combat drugs.

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Homelessness and Vulnerability among Adults With and Without Alcohol Problems

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ABSTRACT

While many works compare traits of homeless adults across levels of alcohol use, few specifically consider whether drinking status affects determinants of either homelessness or "vulnerability" to homelessness. This paper relies on a 1986 Chicago, Illinois sample (n = 535) to consider the potential contributions of resources, social network characteristics, disaffiliation, and mental health problems. Results suggest that resource problems may determine homelessness regardless of drinking status. But drinking-associated problems may raise the resource threshold for "vulnerability," reduce the protection afforded by social networks against both homelessness and "vulnerability," increase the deleterious impact of disaffiliation, and spur complicating mental health problems. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Homelessness; Poverty; Comparison studies; Correlates of alcohol use

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INTRODUCTION

Numerous scholarly works suggest that homelessness occurs more readily among those United States adults who have alcohol-use-associated problems. For example, more sophisticated local surveys find that from 25 to 60% of undomiciled adults have, or had, problems with alcohol (reviewed in McCarthy et al., 1991; Drake et al., 1991; Fischer and Breakey, 1991). To be sure, the most critical review sets the trustworthy point in time alcohol misuse rate for homeless somewhere near 28% (Lehman and Cordray, 1993). However, this is still much higher than the 9.7% one-year alcohol misuse and dependency rate in the United States (Kessler et al., 1994). Local comparison studies similarly suggest that alcohol-use-associated problems are approximately three to five times more common among the adults who lack a home than among typical domiciled individuals (Welte and Barnes, 1992; Fischer and Breakey, 1991; Koegel and Burnam, 1988). Other works find that the problems typically arise before the loss of the domicile (Johnson and Barrett, 1991; Koegel and Burnam, 1988). Alcohol-use-related problems have been found to distinguish certain samples of homeless and domiciled very poor individuals (Sosin, 1992; Lin et al., 1990), and to be greater when homelessness is chronic (Piliavin et al., 1993). There is evidence that alcohol-use-related problems have been overrepresented among homeless adults in the United States at least since the post-World War II period (Bahr and Caplow, 1973; Bogue, 1963).

Recent works have begun to further analyze whether the combination of alcohol-use-related problems and homelessness is associated with other "risk" factors. These studies so far convincingly suggest that homeless adults who also are problem drinkers have unusually high levels of mental health symptomatology (Szcucki et al., 1994: Cohen and Krating, 1993; Drake et al., 1991; Cohen and Burt, 1990; Koegel and Burnam, 1988). Works also on occasion (in some communities) report that problem drinking is associated with being male, divorced or separated, attached to income maintenance programs, of poor health, or detached from employment and the social network (Cohen and Krating, 1993; Welte and Barnes, 1992; Fischer and Breakey, 1991; Calsyn and Morse, 1991; Cohen and Burt, 1990; Koegel et al., 1990; Burnam and Koegel, 1988; Roth and Bean, 1987). Nevertheless, it can be argued that the studies provide the safest grounds for discussing traits that develop in some samples of homeless problem drinkers at some point in their life histories (Drake et al., 1991; Fischer and Breakey, 1991). Typical works are not necessarily aimed at testing perspectives (rudimentary theories) on the determinants of homelessness (see Note 1). Representative studies are summarized in Table 1.

It is useful to focus on four perspectives that more systematically consider how drinking problems interact with other traits in the development of homelessness. As summarized in Table 2, each of these involves a plausible, if incompletely tested, argument. 1) The *resource* perspective posits that the residential instability of those with alcohol-use-related problems reflects an especially great absence of the tangible goods and services that sustain domiciled life (Corrigan and Anderson, 1984). Although stated in terms of differences for the sake of developing testable hypotheses, this perspective is partly motivated by the contrasting strong argument that alcohol misuse is only one of a number of "risk factors" that increase sensitivity to certain economic conditions; resource problems allegedly are equally shared by problem drinkers and nonproblem drinkers (Whittman, 1987; Koroloff and Anderson, 1989; Koegel et al., 1990; Blumberg et al., 1973). 2) The *social network* perspective suggests that afflicted adults may be particularly unable to avoid total destitution without the aid of social supports (Thoits, 1982; Turner, 1981; Ell, 1984; Cohen and Syme, 1985; Specht, 1986; Sarason et al., 1990). The most common argument seems to be that problem drinkers lack ties of any kind (Fischer and Breakey, 1991), and thus are at special risk because they receive less help reducing emotional stress and economic distress. 3) The *disaffiliation* perspective includes the fascinating, if quite controversial, possibility that alcohol misuse is combined with a peculiar isolation or withdrawal from society (when the causes and effects range beyond those mentioned in the social network perspective). For example, earlier and recent works suggest that "disaffiliation" among the residentially unstable problems drinkers in skid row might be associated with low motivation or ability to retain helpful connections to society (Robertson et al., 1993; Gribsby et al., 1990; Shipley et al., 1989, Bahr and Caplow, 1973, Wiseman, 1970; Wallace, 1965; Bogue, 1963; Merton, 1957). 4) Finally, the *mental health* perspective encompasses the previously documented suggestion that those with alcohol-use-related problems are particularly "at risk" when further disabled by mental health problems (Drake et al., 1991).

A special contribution can be made by considering the utility of these perspectives for distinguishing problem drinkers and nonproblem drinkers among both "vulnerable" and homeless adults. This differentiated examination might help locate the traits that place people in risky situations, those that are directly implicated, and perhaps those that determine the passage between "vulnerability" and homelessness. Indeed, there is clear evidence that individuals become homeless after experiencing a vulnerable situation in which they are "at risk" due to very low incomes, long periods of unemployment or partial employment, and limited family resources. Only some such individuals experience the loss of the domicile. Reasons for the final decline may or may not

Table 1.

Overview of Perspectives

Perspective	Critical parameters	Argument in brief	Hypothesized conditions leading to homelessness	Advantages	Limitations	Unresolved issues problems	References
Resources	Tangible goods and services	Homelessness occurs when individuals lack access to tangible benefits	*Facilitating*: High rents, living alone, unemployment *Inhibiting*: Welfare or work benefits, human capital	Ties homelessness to concrete issues that are consistent with increasing size of homelessness problem and that may be ameliorated	May vary in applicability with social conditions; does not suggest possible personal causes of lack of resources; deals with problems that are both socially conflictual and expensive to ameliorate	Never before tested across levels of alcohol misuse; may be more closely tied to vulnerability	Baxter and Hopper (1981); Blumberg et al. (1973); Corrigan and Anderson (1984); Koegel et al. (1990); Sosin (1992); Whittman, (1987)
Social network	Ties with others, supports received from the social network	Homelessness occurs when emotional and tangible supports are lacking	*Facilitating*: Lack of network members *Inhibiting*: Provision of supports by network members	Consistent with literature suggesting that homeless adults have small networks; acknowledges interactive nature of homelessness	Difficult to change with a treatment program; assumes ties to others are independent of personal traits; may not be equally predictive across levels of alcohol misuse	Ambiguous results in the literature; impact may vary by gender; most studies measuring networks and homelessness do not consider alcohol misuse	Blumberg et al. (1973); Fischer and Breakey (1991); Goodman (1991)

Disaffiliation	Disinterest in ties with others, lack of ability to form ties	Homelessness occurs to those who do not form attachments to social institutions	*Facilitating*: Past experiences suggesting or causing the lack of ties *Inhibiting*: Marriage	Consistent with traditional view of homelessness; distinguishes being at risk from being homeless	Ambiguous on causal path; can be used stereotypically; difficult to confront with treatment programs	Role in risk for homelessness is unclear; role of psychological predispositions is untested; interactions with alcohol misuse are assumed and not tested	Bahr and Caplow (1973); Bogue (1963); Grigsby et al. (1990); Merton (1957); Robertson et al. (1993); Shipley et al. (1989); Wallace (1965); Wiseman (1970)
Mental health disabilities	Mental health problems, release from mental hospitals	Homeless individuals are unable to obtain resources due to mental health problems	*Facilitating*: Mental health problems as recognized by symptomotology or mental hospitalization *Inhibiting*: N.A.	Seems consistent with timing of deinstitutionalization and increase in homelessness	May be more important to vulnerability; mechanisms leading to homelessness are vague except when overlapping with other perspectives	Reasons mental health problems might independently influence homelessness; measurements still inexact; lack of impact according to previous comparison studies	Drake et al. (1991); Koegel and Burnham (1988); Szczucki et al. (1994); Toro et al. (1995)

Table 2.

Selected Empirical Studies Investigating Homelessness and Alcohol Misuse

Author	Year	Country	Type *Ss*	# *Ss*	Control group	Location	Type drinker	Results/Implications	Limitations/unresolved issues
Bahr and Caplow	1973	USA	Skid row men	203	Camp LaGuardia inmates, Park Slope neighborhood residents, Park Avenue residents	New York Bowery	Drinkers and nondrinkers included	Far reaching comparison survey of homeless and domiciled populations. Concludes that disaffiliation is exaggerated as cause of homelessness. However, skid row men marry less frequently, have lower status jobs, "fewer close friends and drink more heavily"	Primarily univariate analyses; more evidence for disaffiliation than authors suggest; incomplete distinction of skid row men by drinking patterns; homelessness is defined as living on skid row
Blumberg et al.	1973	USA	Skid row men	Varies from 603 to 2,249	None for most analyses	Philadelphia	Skid row resident, census and resident interview	Survey portion finds that vast proportion of skid row sample misuses alcohol, especially if White; majority of sample members work, but most only part of the year; few respondents both like the neighborhood and identify with skid row	No comparison group; small range of variables; skid row and literal homelessness are not distinguished
Calsyn and Morse	1991	USA	Homeless men	165	Predicts drinking problem within sample	St. Louis	Those identified by MAST	Multivariate analysis shows that problem drinkers, compared to other sample members, had higher pre-homeless stress, were older, and had higher current life satisfaction. Psychiatric symptoms, previous hospitalization and marital status are only predictive of drinking in bivariate analyses	Does not include analysis among domiciled individuals; only includes male shelter users from one location; cause and effect not clear due to use of drinking as a dependent variable
Cohen and Burt	1990	USA	Stratified random sample of homeless program userss in cities	1,704	Comparisons with those having mental health problems, multiple symptoms, no symptoms	National	Drinker and drug user with chemical dependency treatment experience	Those with chemical dependency treatment are most likely to receive general assistance, least likely to receive income from working; they tend to have histories of jail, prison, or mental hospital experience	Only focuses on those having chemical dependency treatment, no direct comparison to domiciled but vulnerable population

Fischer	1989	USA	80 studies of alcohol and drug prevalence among the homeless since 1980	N/A	N/A	National	N/A	Reported alcohol and drug prevalence rates are strongly influenced by choice of sampling; published estimates of alcohol misuse among the homeless range from 2 to 90% and drug-use-related problems may affect 70%	Comparing alcohol and drug prevalence rates across past studies is difficult, since many fail to adequately describe sampling sites and methods
Koegel and Burnam	1988	USA	Street-dwelling and sheltered homeless adults	379	None	Los Angeles	Alcohol problem defined as meeting DSM-III criteria for abuse or dependence	62.9% of sample at some point met DSM criteria for alcohol abuse/dependence; homeless adults with alcohol problems had longer homeless histories than those without alcohol-use-related problems	Study only presents descriptive analyses looking at differences between homeless adults with and without alcohol-use-related problems
Koegel et al.	1990	USA	Homeless adults	379; 102 chronic "substance abusers;" 46 dually-diagnosed adults	The other interviewed homeless adults	Los Angeles	Inner-city homeless; lifetime DIS diagnosis	Few special subsistence strategies of substance misusers; substance misusers are less likely to receive welfare benefits except if they also have a mental health disorder	No comparison to domiciled vulnerable adults; little examination of social network or disaffiliation perspectives; limited sampling frame
Linn et al.	1990	USA	Homeless medical clinic users	214	250 domiciled medical clinic users	California beach community	Self-identification and selected CAGE questions	Homeless respondents more likely to experience substance misuse and certain symptoms of mental illness	Differences across groups are small; analysis is univariate; drinkers and nondrinkers are not distinguished
Szczucki et al.	1994	USA	Currently hospitalized (mental health), previously hospitalized and never hospitalized homeless men	640	Compares hospitalized and never hospitalized men	New York City	Those with lifetime SMAST scores of three or more	Hospitalized men are more likely to also evince substance misuse	Relations are cross-sectional; no independent sample of adults with substance misuse problems
Welte and Barnes	1992	USA	Homeless shelter and/or SRO residents	412	Telephone household respondents (5,070); New York City nontelephone respondents (399); college respondents (483)	New York City and upstate New York	Range from current abstainers (10%) to heavy drinkers (13% drinking more than 20 drinks per day)	Drinkers among homeless/marginally housed sample consume nearly 8 times as much alcohol as drinkers in the general population. Covariance structural modeling showed evidence that alcohol misuse is a factor leading to homelessness	Use of shelters and SROs as basis for sampling frame under-represents the homeless living on the streets. Structural modeling method used suggests, but does not prove causality

fully mirror those bound to "vulnerability" (or homelessness might almost randomly occur to vulnerable adults; Arce and Vergare, 1984; Baxter and Hopper, 1981; Colson, 1990; Drake et al., 1989; Hoch and Spicer, 1985; McCourt, 1990; Rossi, 1989; Rousseau, 1981; Sosin et al., 1988, 1990; Toro et al., 1995). The current paper thus uses a data set that seems to represent homeless and "vulnerable" adults to conduct comparisons relevant to examining the four perspectives.

METHODS

Sampling Strategy

The data set is derived from a questionnaire administered to a random sample of homeless and very poor domiciled adults who obtained their main meal of the day for free at a program in Chicago during the summer of 1986. It represents adults from the three strata of relevant programs: 1) shelters for the homeless, 2) meal programs that do not serve the elderly (such as soup kitchens and drop-in centers that serve the main deal), and 3) long-term community residential programs that serve only the indigent and do not charge temporary residents, including programs focusing on mental illness and alcohol misuse. The 535 respondents comprise 81.5% of the strata members who were approached at 32 separate sites (see Note 2).

This sample is in part useful because it should represent a rather large proportion of local homeless adults; a study of Chicago street and shelter dwellers finds that 72% eat at meal programs (more narrowly defined than the programs sampled here) other than shelters each month, and 80% stay in shelters. Many of the latter serve the main meal of the day to residents who do not eat at meal programs, and thus are represented here (Rossi et al., 1986; the other shelters refer individuals to the sampled meal programs). At least two examinations of other communities report similar or greater frequencies of program use (Roth et al., 1985; Burnam and Koegel, 1988). Representativeness seems particularly likely because the demographic and economic traits of homeless sample members are similar to those of the respondents to other cross-sectional surveys of urban undomiciled adults (Sosin, 1992; Koegel et al., 1990; Rossi et al., 1986; Roth et al., 1985) (see Note 3).

While "vulnerability" is a theoretical concept that might be operationalized in many ways, the current sample seems to capture a useful subsample of relevant individuals—housed adults who are on the verge of homelessness. This subsample entails the represented population of domiciled meal program users; there is evidence that most who become homeless first use the sampled meal programs, that many domiciled adults use the programs as part of a strategy of successfully avoid the loss of a home, and that previously homeless but still

"vulnerable" individuals often use the facilities as part of the attempt to avoid a return to homelessness (McCourt, 1990; Sosin et al., 1988; Colson, 1990). A further suggestion of utility stems from analyses suggesting that this subsample mirrors poor household heads on such traits as average age, race, education, previous history of psychiatric hospitalization, and symptoms of mental illness. The subsample tends to evince differences that may indicate the expected "vulnerability"—greater homeless experience, reduced work history, a higher prevalence of reported alcohol problems, and a higher proportion of males. The last trait is likely to be linked to "vulnerability" because men generally do not have custody of children and thus are only eligible for benefits of the less generous, and unstable, General Assistance Program. Men also are less likely to avoid homelessness (as defined here) by permanently living with other adults (Baker, 1994). Of course, "vulnerability" remains a theoretical concept; its operationalization is an on-going research concern (Toro et al., 1995; Ringheim, 1990; Burt and Cohen, 1989; Rossi, 1989).

There may be controversy over the inclusion of the strata of residential programs that do not charge (some ask long-term residents for copayments) nor obtain per diem government payments. However, the programs in this strata indeed serve as both shelters and long-term residences for "vulnerable" adults; for example, they include facilities classically thought of as religious shelters and religious rehabilitation facilities (Wiseman, 1970) (see Note 4). The analyses compensate for the possibility that adults visit programs in this or any strata with unusual frequency by assigning weights. These vary with the average number of times strata members report attendance over the course of a month, which was in part determined from return visits.

Independent Variables

The survey was designed to include an extensive array of variables relevant to the perspectives. It also incorporates considerable information on the relative timing of homelessness. This helps ensure that relevant variables tap conditions that existed prior to the most recent loss of a dwelling. Nevertheless, the number of items must be limited here to eliminate some factors that cannot easily be temporally placed, and that are likely to be affected by homelessness (or even "vulnerability"). Restrictions also avoid overloading the multivariate analyses.

The resource perspective is represented by *occupational* factors including a) the percent of time respondents report working in the past, and b) whether respondents claim current (or pre-homeless) employment (Sutherland and Locke, 1936; Hopper et al., 1985). It also includes the *institutional* or nonmarket factors of (a) income maintenance benefits, b) lack of coresidence with

other adults, and c) rent costs. The last three items are included because homelessness or even "vulnerability" might be avoided (for problem drinkers, nonproblem drinkers, or both) when individuals have the supports of welfare, an adult with which to share expenses, or low rents. This has a special logic because the apparent increases in the rates of homelessness and in "vulnerability" (as measured by extreme poverty) over the last fifteen years (Rossi, 1989) coincides with, and thus might be partly caused by, growing difficulties in the considered areas (Nelson, 1994; Wilson, 1987; Garfinkel and McLanahan, 1986; Sosin, 1986; Hoch and Spicer, 1985; Wiseman, 1970). Further, similar variables predict the lack of a domicile in some studies that do not focus on alcohol misuse (Toro et al., 1995; Sosin, 1992; Wagner and Cohen, 1991). For homeless respondents, all resource-related items but the first represent respondent circumstances as they existed immediately before the loss of the domicile (see Note 5). The lack of coresidence is coded as "yes" for single parents as well as for those who live alone.

Variables representing the *social network* perspective include a) the number of network members (family and friends) listed by respondents, b) the extent to which sample members report obtaining tangible support—money, shelter, or food—from family, and c) the extent to which the sample members report obtaining these supports from friends. The latter two items are included in light of work pointing to the role of tangible resources in sharing the risk of poverty (Sarason et al., 1990; Wilson, 1987; Specht, 1986; Cohen and Syme, 1985; Ell, 1984; Thoits, 1982; Turner, 1981; Garbarino and Crouter, 1978). The measures count the number of positive responses (0 to 3) to questions concerning whether each of three goods (cash, food, shelter) was obtained in the 30 days in the immediate past. The utilized questions distinguish homeless and domiciled friends. The current variables exclude the former.

Disaffiliation is captured by a) foster care experience as a child, b) congregate care experience as a child, c) military service, and d) having never married. While certain authors consider almost all resources and social relations as indicators of the concept in its broadest sense, the relevant perspective is most compelling when focusing on such concrete and plausibly causal events and situations. We therefore do not include many measures, such as those related to acculturation to homelessness—a process which in theory can operate through disaffiliation or independently, but which is difficult to measure and unlikely to be predictive according to previous work (Piliavin et al., 1993; Blumberg et al., 1973). The variables that are included here, which are also referred to by other recent studies, may indicate or cause the attenuation of bonds between an individual and the social order. They also clearly precede the most recent period of homelessness. That is, congregate care has been claimed to predict homelessness because it signifies a lack of previous integra-

tion into society, while foster care is also deemed possibly relevant (Susser et al., 1987, 1991). Military service is allegedly bound up with the lack of a domicile because it leads to, or follows, alienation from conventional society (Momeni, 1990). Having never been married is widely posited to indicate an unwillingness or inability to form social ties very early in adulthood (Bahr and Caplow, 1973; Wallace, 1965) (see Note 6).

Mental health disabilities are represented by a) previous psychiatric hospitalization and b) mental illness symptomatology. The latter is measured by the average score on the GSI (Global Symptom Inventory), a 53-item, four-point scale of mental distress that reliably distinguishes psychiatric inpatients or outpatients from nonpatients. The measure is not likely to vary over short periods of time (Derogatis and Spencer, 1982). Finally, there are five *background* variables: gender, age, race (coded as percent Black due to the sample composition), education, and previous homeless experience. The last is clearly a background variable because the average period occurred 46.6 months before the interview (the median is 12 months).

The four perspectives seem to overlap, but they are distinguished because they isolate traits that may have differential implications. For example, while individuals who are disaffiliated may also lack a social network, an absence of ties does not necessarily occur due to a tendency to withdraw from others. Further, disaffiliation may encourage a lack of participation in other things than the network of friends and family. Similarly, while the lack of coresidence can indicate a social network problem as well as an institutional problem reducing resources, it clearly in part leads to a lack of financial resources. It seems to cause poverty for this reason (Rosenheck and Fontana, 1994; Rossi, 1989; Garfinkel and McLanahan, 1986). In sum, this paper compares both domiciled and homeless sample members across drinking status on all described traits while distinguishing perspectives. It then uses multivariate procedures to analyze the transition between the two stages. The multivariate analyses examine the contribution of each trait when controlling for all others, including those that may seem to overlap.

DESCRIPTIVE RESULTS

Sample Traits

Table 3 reports scores on the utilized independent variables. These suggest that individuals in the entire sample, as well as homeless sample members, have background characteristics that are roughly similar to those of the adults represented in most national or local studies of homelessness (Koegel et al., 1990; Burt and Cohen, 1989; Rossi, 1989; Roth et al., 1985). Current sample members thus have an average age around the mid-thirties, are heavily male,

Table 3.

Sample Characteristics (standard deviations)[a]

	Total sample: Meal program users (N = 442)
Background traits:	
Average age	37.0 (13.0)
Percent Black	71.1 (45.5)
Percent homeless before	52.2 (50.1)
Years of education	11.1 (2.4)
Percent female	29.1 (45.5)
Resources:	
Percent of adult life worked	54.1 (27.3)
Percent currently working	33.1 (47.2)
Percent receiving welfare	49.5 (50.2)
Percent living with no other adult	55.1 (49.9)
Average rent (dollars)	137 (97)
Social network:	
Number of network members	5.6 (5.2)
Tangible supports from family	1.1 (1.2)
Tangible supports from friends	0.9 (1.1)
Disaffiliation:	
Percent with foster care placement	7.9 (27.0)
Percent with childhood congregate placement	9.0 (32.6)
Percent with military experience	24.2 (42.9)
Ever married	43.1 (49.7)
Mental health disabilities:	
Percent with mental hospital experience	15.5 (36.3)
Symptomotology	0.737 (.646)

[a]Statistics only use cases that have no missing data on all variables to conform to the following multivariate analyses.

evince educational levels averaging about at high school graduation, and report considerable prior homeless experience (not including the current period of homelessness). In Chicago, where the vast majority of poor adults are Black, the sample members are also so typified.

The respondents more generally seem characterized by a paucity of the measured supports. Sample members report they worked about half of the time as adults. About 33% report working at the time of the survey. Further analyses suggest that recent work is almost uniformly part-time or day labor. Even though almost all sample members should be eligible, results suggest that about half claim to receive income maintenance benefits. Only a similar proportion reports living with another adult. The average rent is slightly less than that reported for Chicago poor individuals at the time.

While the social networks do not seem so small as to suggest total isolation, respondents claim to receive little tangible help from these contacts. Experience with foster or congregate care seems somewhat high and thus possibly problematic, because interpolations from national data suggest a race and sex-corrected figure of 8.3% for the two types when combined (Children's Defense Fund, 1978). Symptomatology of mental illness hovers around the level alleged to indicate a need for treatment for over 40% (Derogatis and Spencer, 1982)—even if scores are a bit lower than those calculated for a group of AFDC women in a neighboring state (Berlin and Jones, 1983). Reported mental hospital experience characterizes an also elevated 16%.

Continuing to discard cases with any missing data on the variables described above, further analyses suggest that there are 104 domiciled individuals with defined alcohol problems and 189 without; 41 homeless individuals with alcohol problems and 108 without. These frequencies are calculated when attributing homelessness to sample members who report either living in a shelter; sleeping in such unconventional locations as abandoned buildings, automobiles, doorways, alleys, or parks; residing with a friend or relative and not paying rent when the stay is expected to be short (under 14 days) and no other permanent option exists; or living in a treatment program when the stay is for no longer than 90 days and the individual has no permanent residence to which to return. The last two aspects take the middle ground among controversies surrounding the housing status of adults who have temporary domiciles. Drinking-associated problems are similarly ascribed to sample members who admit to either binge drinking, alcohol consumption of at least 60 standard ounces of alcohol in the last month, passing out, blacking out, experiencing tremors or shaking, or experiencing seizures that are due to drinking. These indicators avoid the bias caused by referring to experiences that occur more readily to adults when they are homeless or nearly homeless (such as being jailed for possession of alcohol). Perhaps it is worth noting that the high point-in-time prevalence of alcohol-use-related problems in the domiciled as well as home-

less subsample may suggest that alcohol misuse is a "risk factor" for "vulnerability" as well as for homelessness; the previously mentioned, lower 1-year national average misuse or dependency rate does not appear to vary greatly with income for the general population (Kessler et al., 1994).

Comparisons among Domiciled Meal Program Users

The comparisons of domiciled meal program users who vary in drinking status are reported in numerical columns 1 and 2 of Table 4. Statistically significant relations suggest that those represented domiciled adults who also are problem drinkers are (much) more likely than nonproblem drinkers to be male. This is consistent with previous reported differences among homeless, and perhaps other, adults (Gallant, 1987; Welte and Barnes, 1992). The sample members with drinking problems also tend to evince higher levels of education ($p = .055$), while they more frequently report previous homeless experience. There is a statistically significant difference in the proportion Black, but this seems to be a function of the gender ratio. Represented domiciled Whites are more likely to be men (who are more frequently problem drinkers); the relation between drinking status and race is lost within gender (even if the population of women is quite small).

Statistically significant relations involving variables representing the perspectives, while a bit more sparse, at times join the nearly statistically significant difference in education to suggest that domiciled meal program users actually have slightly greater resources and skills when they also report alcohol problems. The one relevant relation among resource measures suggests that those domiciled sample members who have reported drinking problems are more likely to have welfare benefits than nonproblem drinkers. The two relations involving the social network similarly suggest that those who report alcohol problems enjoy more resources from family members and friends. While there are no located differences involving measures of disaffiliation, the one statistically significant relation among mental health measures suggests that represented domiciled problem drinkers have higher levels of symptomatology of mental illness. These, like the alcohol problem itself, may indicate problems that constrain use of resources and skills.

Comparisons among Homeless Meal Program Users

Comparisons among the homeless adults, which are reported in numerical columns 3 and 4 of the same table, in some ways mirror findings for the represented domiciled individuals: statistically significant relations again suggest that those with reported alcohol-use-related problems are more heavily male, report receiving more supports from friends, and evince high scores on

Table 4.

Descriptive Statistics by Alcoholism and Homeless Status—Weighted (standard deviation)[a]

	Domiciled adults without alcohol problems (N = 189)	Domiciled adults with alcohol problems (N = 104)	Homeless adults without alcohol problems (N = 108)	Homeless adults with alcohol problems (N = 41)
Background traits:				
Average age	38.2	37.1	33.6	38.8*
	(15.3)	(10.9)	(11.1)	(10.0)
Percent Black	69.1	80.2*	66.0	68.4
	(47.3)	(41.0)	(45.1)	(47.0)
Percent homeless before	45.2	66.3***	45.9	63.8
	(50.9)	(48.6)	(47.4)	(48.6)
Years of education	10.8	11.4	11.2	11.5
	(2.8)	(2.1)	(2.3)	(1.3)
Percent female	35.5	7.4***	48.4	9.8***
	(49.0)	(26.9)	(47.6)	(30.0)
Resources:				
Percent of adult	51.9	54.0	54.9	63.2
life worked	(29.4)	(24.9)	(27.3)	(21.7)
Percent currently working	30.8	39.1	29.8	35.5
	(47.3)	(50.2)	(43.6)	(48.4)
Percent receiving welfare	54.3	70.4**	24.2	30.9
	(51.0)	(47.0)	(40.8)	(46.7)
Percent living with	49.0	42.6	71.8	77.7
no other adult	(51.1)	(50.9)	(42.8)	(42.1)
Average rent (dollars)	126	122	161	183
	(86)	(70)	(115)	(130)
Social network:				
Number of	6.9	5.7	3.6	3.5
network members	(6.4)	(4.0)	(3.2)	(3.4)
Tangible supports	1.1	1.4*	0.9	0.9
from family members	(1.2)	(1.3)	(1.1)	(1.1)
Tangible supports	0.8	1.3***	0.6	1.1*
from friends	(1.0)	(1.1)	(0.9)	(1.2)
Disaffiliation:				
Percent with foster	6.3	6.9	10.8	11.1
care placement	(24.9)	(26.1)	(29.5)	(31.8)
Percent with childhood	5.2	5.7	13.8	24.3
congregate placement	(22.7)	(23.8)	(41.6)	(53.1)
Percent with	19.6	23.3	22.1	53.4***
military experience	(40.6)	(43.5)	(39.5)	(50.5)
Ever married	47.9	36.6	40.6	43.4
	(51.1)	(49.6)	(46.8)	(50.1)
Mental health disabilities:				
Percent with mental	13.3	12.6	19.3	24.3
hospital experience	(34.7)	(34.2)	(37.6)	(43.4)
Symptomotology	0.599	0.981***	0.647	0.969***
	(0.644)	(0.668)	(0.502)	(0.702)

[a]Statistics only use cases that have no missing data on all variables to conform to the following multivariate analyses. For comparison to group without alcohol problems: *$p < .05$, **$p < .01$, ***$p < .001$.

potentially debilitating mental health symptomatology. The relation to previous homeless experience dips to just below statistical significance ($p < .055$). But statistical significance is clearly lost for variables that indicate resources from receipt of welfare benefits and supports from family members. This suggests that problem drinkers lose some apparent advantages over nonproblem drinkers if they are homeless rather than in the "at-risk" group.

Two differences not suggested earlier emerge. One, which has been noted in the review of previous studies, suggests that homeless individuals with alcohol problems are older than undomiciled nonproblem drinkers. The second, which is less fully anticipated, suggests that those in the problem drinker group are more likely to report experience with military service. The last, quite large, relation is not simply a function of the sex ratio of the groups; it is replicated for comparisons within separated samples of women and men. This begins to demonstrate the differentiating ability of a measure of disaffiliation.

LOGISTIC REGRESSIONS

The varied results are further extended with the aid of logistic regressions that model the determinants of being homeless rather than domiciled. In this analysis the subsamples of drinkers and nondrinkers are separated, and models predicting homeless are developed within each. In light of previously mentioned evidence that most homeless individuals use the free meal programs before suffering the loss of the domicile as well as between periods of homelessness, results can be argued to help determine whether the measured traits are bound up with the direct transmission into homelessness from vulnerability (Toro et al., 1995). Indeed, Table 5 reports that the variables in each equation differentiate the domiciled (and apparently vulnerable) from the homeless meal program users represented here; the intercept only -2 log likelihood statistic is reduced by between 30 and 40% by the included traits. This occurs even though the *number* of statistically significant coefficients is limited; the *strength* of these coefficients tends to be quite pronounced. While this is not reported in a table, further analyses suggest that none of the reported relations among drinkers change in statistical significance when a measure of the severity of the reported drinking problem is added to the equation.

The only statistically significant coefficient involving background variables in an indirect way mirrors descriptive comparisons, suggesting that nonproblem drinkers are more likely to be homeless rather than domiciled meal program users when they are younger (perhaps because older adults learn how to remain domiciled when in extreme poverty if drinking does not interfere). Measures of occupational conditions are also generally unpredictive of being a homeless rather than domiciled meal program user. This is the case for both problem drinkers and nonproblem drinkers. Of course, the evidence still suggests that the lack of work contributes to homelessness by placing individuals

Table 5.

Logistic Regressions and Predicting Homelessness Coefficients and Standard Errors

	Meal program users without alcohol problems (N = 297)	Meal program users with alcohol problems (N = 145)
Background traits:		
Intercept	2.715*	0.332
	(1.154)	(2.342)
Average age	–0.056***	–0.038
	(0.161)	(0.033)
Black	0.002	–0.327
	(0.377)	(0.656)
Percent homeless before	–0.212	–0.909
	(0.344)	(0.578)
Years of education	–0.089	–0.170
	(0.067)	(0.140)
Female	–0.057	3.860
	(0.645)	(2.736)
Resources:		
Percent of adult life worked	0.007	0.007
	(0.006)	(0.013)
Currently working	0.418	–0.426
	(0.367)	(0.617)
Receiving welfare	–1.696***	–1.604**
	(0.356)	(0.516)
Living with no other adult	1.109**	1.484*
	(0.365)	(0.657)
Rent (dollars)	0.004*	0.007*
	(0.002)	(0.004)
Social network:		
Number of network members	–0.399***	–0.087
	(0.096)	(0.088)
Network–gender interaction	0.222	–0.530
	(0.116)	(0.499)
Tangible supports from family	0.039	0.056
	(0.158)	(0.297)
Tangible supports from friends	–0.231	0.279
	(0.179)	(0.276)
Disaffiliation:		
Foster care placement experience	0.256	–0.083
	(0.668)	(1.132)
Congregate placement experience	0.256	1.604*
	(0.627)	(0.815)
Military experience	0.358	2.010**
	(0.456)	(0.652)
Ever married	0.001	0.324
	(0.363)	(0.576)

(*continued*)

Table 5. *Continued*

	Meal program users without alcohol problems (N = 297)	Meal program users with alcohol problems (N = 145)
Mental health disabilities:		
Mental hospital experience	0.154	0.977
	(0.454)	(0.753)
Symptomotology	0.071	0.101
	(0.270)	(0.465)
-2 Log likelihood	372.829	175.731

*$p < .05$, **$p < .01$, ***$p < .001$.

in the at-risk population represented here. The equations also suggest that institutional resource problems are among the factors that more fully distinguish homeless and domiciled meal program users. This is the case across alcohol status. Further analyses suggest that, when all other traits are also set to levels predisposing homelessness, the institutional resource variables raise the predicted probability of homelessness from 62.4 to 96.0% for those with alcohol problems, and from 51.2 to 86.2% for the others (a high rent is set at $170 and a low rent at $0; the equation sets age at the average, and gender as male). The relevant coefficients suggest that members of either group are more likely to be homeless when lacking welfare benefits, when failing to coreside with other adults (when domiciled), and when paying higher rents (when domiciled). The last coefficient can be interpreted as just at the .05 level for problem drinkers.

A clearly statistically significant coefficient suggests that the nonproblem drinkers, alone, are more likely to be in the homeless rather than domiciled meal program user subsample when their social networks are smaller. The logistic regressions include an interaction term considering whether men and women benefit differentially (Berkman and Syme, 1979; Brown et al., 1992). A borderline ($p < .055$) relation in the same group suggests that men are particularly unlikely to be homeless when reporting a larger social network. This is consistent with other information about the lack of predictive power of network variables for homeless women (Goodman, 1991), who must have somewhat superior abilities to make use of any supports they have. For nonproblem drinkers who are men, those with a network size of zero have a 45.2% increment in their predicted probability of homelessness when compared to those of 10 network members (with traits from other perspectives set at predisposing levels).

Coefficients attached to two measures stemming from the disaffiliation view are predictive only among the group of problem drinkers: results suggest that the meal program users who experienced childhood congregate care, and who experienced military service, are more likely to be homeless. These relations are quite powerful, increasing the predicted probability of those with predisposing levels on all other traits from 39.3 to 96.0%. Further tests fail to suggest a specific effect of military wartime trauma, because peacetime and wartime service are similarly predictive when included in the equation separately. In contrast, coefficients attached to variables indicating mental health problems do not reach statistical significance in either group.

DISCUSSION

The utility of these comparisons are most apparent when considering potential alternative strategies for developing contrasts across homeless status (within groups differing on alcohol problems). For example, it would be possible to instead compare a sample of homeless individuals to a cross-section of domiciled adults. This procedure might uncover differences that broadly capture the special characteristics of those who lack a home, but it would not distinguish whether the traits are overrepresented among all of the poor or vulnerable, or only among those who are homeless. Similarly, comparisons between homeless adults and residents of a given low income neighborhood utilize a domiciled group of unknown relevance. And comparisons of homeless adults to welfare recipients, while perhaps appropriate to isolate determinants for families in New York or a few other cities where nearly all relevant homeless adults received welfare in the immediate past (Knickman and Weitzman, 1989), otherwise bias consideration of receipt of welfare benefits, or of other traits that relate to it. All such comparisons also have two sampling frames. They thus are of questionable utility for multivariate analyses. In contrast, the meal program user sample has some internal integrity and a single sampling frame. While the multivariate results cannot explain why some individuals are poor, and while work with other samples would be useful, the current results seem to join descriptive analyses in locating reasonable and readily interpretable findings. The major findings for adults with drinking problems are summarized in Fig. 1.

Resource Perspective

A literal reading of the findings concerning resources implies that the lack of work puts problem drinkers and nonproblem drinkers *at risk* for homelessness. That is, meal program users, who seem to represent individuals who have the potential to become homeless, generally lack work. Institutional re-

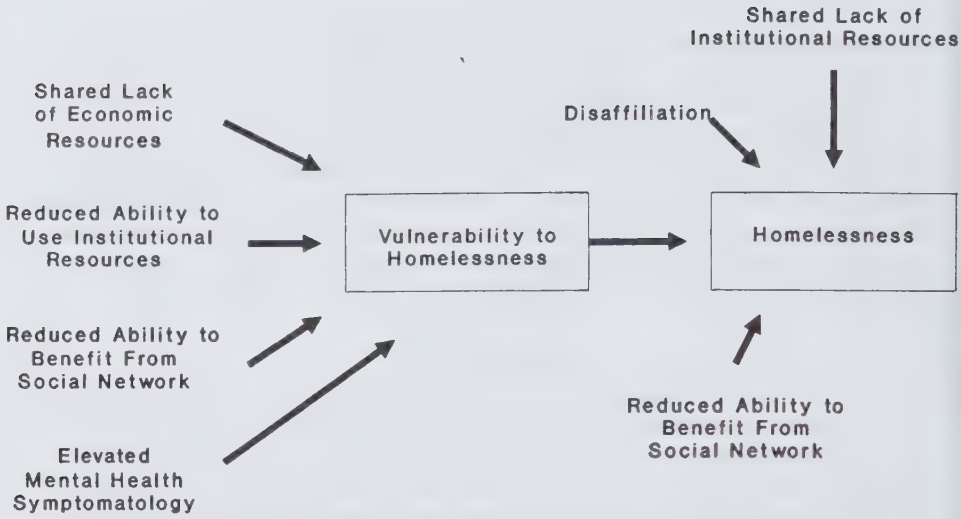
Shared Lack of Institutional Resources
Shared Lack of Economic Resources
Disaffiliation
Reduced Ability to Use Institutional Resources
Vulnerability to Homelessness
Homelessness
Reduced Ability to Benefit From Social Network
Elevated Mental Health Symptomatology
Reduced Ability to Benefit From Social Network

Fig. 1. Apparent determinants of homelessness among adults who misuse alcohol: Comparisons to other adults.

source factors apparently are especially likely to increase the frequency with which vulnerable individuals lose their dwellings once at risk; these factors predict being homeless rather than a domiciled user of free meal programs. Such results are consistent with the fact that the homeless population is much more limited than the universe of very poor individuals (at any one point in time); this implies that poverty must only have a moderate relation to homelessness unless joined with other concerns. As previously noted, the specific role of institutional factors in the direct decline is consistent with previous studies as well as with the decline in availability of the relevant supports in the time period in which homelessness increased.

Perhaps results for problem drinkers mirror those for nonproblem drinkers because many very poor adults who misuse alcohol retain some aspects of the typical abilities to make use of whatever resources they have, even if they physically and socially deteriorate with homelessness. A similar argument can be found in the general literature on alcohol misuse (Fingarette, 1989) as well as in previous work on homelessness. To be sure, such results might seem inconsistent with descriptive examinations finding certain apparent resource differences across drinking status (as best summarized in Fischer and Breakey, 1991). But, while possibly due to variation across specific measures and cities, this may reflect that many previous studies only cover skid rows or other

nonrepresentative geographic areas. Further, they rarely if ever measure resources that are available prior to homelessness. Many actually report a veritable sea of relevant results that are not statistically significant (Koegel et al., 1990, note this), even though reviews pick up on the few differences.

Nevertheless, qualifications to claims of similarity arise from the findings that domiciled individuals who also have alcohol problems more frequently enjoy welfare benefits, and that both domiciled and homeless adults evince somewhat higher levels of education when they also are problem drinkers. These results suggest that alcohol misuse can undermine the use of resources, bringing about an economic crisis in the presence of some skills and incomes. There also is evidence that drinking problems are bound up with a higher prevalence of previous homeless experience. This seems to occur for the simple reason that alcohol use also predicts the lack of a home.

Social Network

Findings can be interpreted to suggest that the social network is also unusually unlikely to help problem drinkers avoid homelessness or "vulnerability." That is, drinkers in either subsample are found to have more network resources than nonproblem drinkers; the network variables fail to demonstrate an impact on homelessness among drinkers; networks seem to help reduce the chances for homelessness of nonproblem drinkers in the sample. These results are anticipated by an insightful traditional study of skid row, which suggests that networks are overwhelmed by the many problems of drinkers (Blumberg et al., 1973). The discrepancy from recent claims that networks of drinkers are smaller may occur because previous studies rarely differentiate living with adults from other types of social relations.

Disaffiliation Perspective

The results involving some measures of disaffiliation lend support to the traditional claim that adults with alcohol problems are so debilitated that they readily become homeless (as compared to being domiciled under very trying circumstances) when also characterized by predispositions to disengage from society. Indeed, the relevant relations are quite powerful. Such findings confirm the decisions to distinguish the disaffiliation perspective from other views and to separate "vulnerability" from homelessness; apparent impacts of measures of disaffiliation are fully independent of the resource and social network deficits, and they also only appear relevant to the direct transition into homelessness. But because these results do not strongly support that disaffiliation has effects due to network or resource problems, they also imply that further re-

search must determine the nature of the represented predispositions. Perhaps it can be tentatively speculated that personality disorders may be implicated. Previous work thus suggests that the disorders help explain the relation between military service, childhood abuse, and homelessness. Personality disorders are also related to both homelessness and drinking status (Toro et al., 1995; Rosenheck and Fontana, 1994; North et al., 1993; Koegel and Burnam, 1988). Military service and group care experience also share, and thus might somehow reflect, earlier involvement with dormlike and shelterlike living (see Note 7).

Mental Health Perspective

Finally, the findings that mental health problems measured by the GSI do not directly predict homelessness are consistent with at least two other studies that do not differentiate by drinking status (Toro et al., 1995; Putchat, 1988). These results are not inconsistent with the possible role of personality disorders, which are not likely to be located by the current measure of symptomatology. But measured mental health problems are sufficiently common among the sampled meal program users to suggest that they play a role in "vulnerability," and thus indirectly contribute to homelessness (see Note 8). This requires further study because other work that highlights the level of symptomatology expresses less certainty about the existence of severe and persistent mental health problems, which are difficult to measure by common instruments (Fischer and Breakey, 1991). The further finding that alcohol-use-related problems are bound up with greater mental health symptomatology (in both the domiciled and homeless subsample), while consistent with previous comments concerning possible implications of dual diagnoses for resources and skills, is subject to similar cautions.

CONCLUSION

It is apparent that homelessness has increased dramatically since the late 1970s. This seems to generally reflect such United States social trends as rising rents (for the very poor), reduced employment opportunities, and a shrinking social service and social welfare system (Blau, 1992; Hopper et al., 1985). While the current results cannot be taken to necessarily generalize to every geographic area, they seem to be consistent with the trends. Nondrinkers and drinkers appear to be at risk when quite poor and characterized by a lack of a work history, a lack of a current job, and according to a plausible interpretation, a high level of mental health symptomatology (that may not be treated). Some represented individuals may become homeless for random or unmeasured

reasons, but there is evidence that a particularly high probability of homelessness occurs when such sample members are further bereft of welfare benefits and other institutional supports that are of declining availability (no matter what individual circumstances are involved in the lack of receipt). Because results also suggest that represented adults generally are over 30 years old, it seems that "vulnerability" is common among those beyond the reach of parental supports.

Results still suggest that alcohol problems have complex effects. The problems seem to lower the resource threshold of the crisis associated with sample membership. Alcohol problems seem to inhibit the extent to which social networks are useful for avoiding homelessness, and they may increase the deleterious effect of some predispositions measured under the disaffiliation view. The problems might also possibly bring about mental health concerns that reduce use of resources by adults who are already "vulnerable." Of course, evidence from other sources also implicates them in the continuing deterioration of adults who are homeless.

Certainly, further research is necessary to conduct multivariate analyses predicting the decline into, or continuation of, "vulnerability." Despite the care the current article takes to distinguish cause and effect, longitudinal research is also necessary. Further, ambiguities about the role of mental health problems and disaffiliation (and the appropriate measurement of these problems) remain. But assuming their reliability, current results have practical implications. They suggest that practitioners need to become well-versed in helping the relevant homeless adults access tangible resources, and perhaps in even substituting for the apparently unhelpful social networks of problem drinkers. Practitioners might also be advised to conceptualize the homelessness problem as encompassing both literal homelessness and "vulnerability." Programs might more readily reverse literal homelessness as a first priority; they are likely to have more difficulty in confronting "vulnerability"—and the profound resource and personal problems that seem bound up with this state. Policy analysts might also pay attention to the central distinction as well as to the apparent centrality of resources in the direct decline into homelessness. The latter is particularly relevant in light of the apparent recent decline in the availability of institutional resources.

For adults with alcohol problems, reduced rates of homelessness might partly depend upon improved availability of many resources. Nevertheless, adults who misuse alcohol also seem to experience homelessness due to a special sensitivity to numerous additional personal problems. This suggests that the impacts of alcohol problems are profound at many levels, even if they operate alongside more widely shared resource limitations.

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NOTES

1. A consensus is developing that the "substance-abuse"-related problems of homeless drinkers are more chronic than those of domiciled drinkers (Casteneda et al., 1993; Welte and Barnes, 1992; Koegel and Burnam, 1988), but this speaks to a different issue.
2. One shelter refused to participate. It was replaced by another that, by chance, served a similar population in the same local area.
3. The sample differs in characteristics slightly from those reported in the Rossi (1989) study of the same city, particularly in the higher representation of women, but this occurs because the Rossi study excludes battered women's shelters and the treatment programs described in the current paper.
4. These are not considered part of the shelter network by the relevant city. This may occur because admission is contingent and some specialized treatment may be offered. In any case, residence in such units does not affect the predictions of homelessness to be described later. This seems to occur because average alcohol consumption of those in the programs does not differ from consumption in the remainder of the sample.
5. For those who were homeless at the time of the interview, the measures of living with no other adults, working (some shelters offer jobs), and receiving income maintenance benefits are corrected with available information to represent the situation occurring when homelessness began. Homeless individuals are coded as lacking work or welfare if they say they became homeless due to the loss of a job or of welfare benefits. They are also coded as lacking work when the date at which they last worked preceded the reported fall into homelessness, unless it is clear that the reported work is carried out at their current shelter. For the small number of homeless individuals who currently have welfare benefits and also reside in shelters that help them obtain this aid, and do not report losing benefits before becoming homeless, welfare status is estimated from an equation predicting receipt for the individuals who just entered the shelter. The measure of rent for the homeless population asks about the last domicile. This measure also incorporates results of a regression with a random residual that estimates data for the 8% of problem drinkers and 12% of others who cannot recall the figure (Little and Rubin, 1989).
6. Note that additional tests suggested that other plausibly relevant variables have no predictive ability. These include divorce and many attitude measures, including a rudimentary scale of the locus of control and a group of items concerning a desire for freedom over conformity. The only exception is the finding that homeless adults with drinking problems are more likely than their domiciled counterparts to *disagree* with a statement professing the preference to "go where I want and do what I want." Since many homeless individuals stay in shelters, cause and effect are unclear.
7. The predictive variables represent experiences that more generally demonstrate ambiguous relations to occupations, social, and family outcomes (Barth and Berry, 1987; Call and Teachman, 1991; Gade et al., 1991).
8. A previous study suggests that some such problems lead to homelessness when accompanied by direct crises; psychiatric patients become homeless when younger, when lacking continued outpatient care, and when lacking SSI and perhaps other welfare benefits.

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"Substance Abuse" Disorders among Runaway and Homeless Youth

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ABSTRACT

This study used systematic sampling methods to recruit a sample of 432 homeless youth from both service and natural "hang-out" sampling sites. According to DSM-III criteria, the majority of respondents were classified as having an alcohol and/or illicit "drug abuse" disorder (71%). The results from multivariate logistic regression analyses indicate that cumulative length of time homeless is positively associated with risk for an "abuse" disorder. The implications of these findings and recommendations for service interventions are discussed. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Adolescents; Homeless; Alcohol misuse; Drug misuse

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INTRODUCTION

During the 1970s and up until the mid-1980s, national surveys reported a dramatic increase in alcohol and other drug use among adolescents and young adults, especially the use of cocaine and crack cocaine. Three surveys in particular, Monitoring the Future which uses a national probability sample of high school seniors (Johnston and O'Malley, 1993), the National Household Survey which samples households nationwide (NIDA, 1993), and the Drug Use Forecasting Program (NIJ, 1992; Golub and Johnson, 1994) which collects information from a sample of arrestees at each of 24 central booking facilities nationwide, reported that drug use among youths peaked by 1979 and then leveled off until 1986, after which drug use declined precipitously.

Despite these findings, there is evidence to suggest that alcohol and other drug use may be increasing among specific subgroups of adolescents and young adults (Kipke et al., 1993, 1995a, 1995b, 1995c; Robertson, 1989). These youth, who are not likely to be sampled by the national surveys of high school seniors or in household surveys, include out-of-school and unemployed youth, runaway and homeless youth, and/or inner-city youth who are involved in the drug dealing and street prostitution subcultures. Recently, rates of alcohol and other drug use among the runaway, homeless, and other street youth populations have been found to be substantially higher than those reported for the general adolescent population as surveyed by national school-based and household surveys (Kipke et al., 1993; Yates et al., 1988). However, to date much of what is known about alcohol and other drug use among runaway, homeless, and other street youth is anecdotal in nature, with findings derived primarily from convenience samples recruited from shelters or other social service agencies. Studies relying upon these convenience samples may ultimately only capture an estimated 30 to 40% of the target population (Kipke et al., 1993).

More recently, several studies have begun to employ representative and systematic sampling techniques in an effort to recruit samples which are representative of the broader runaway, homeless, and other street youth populations. For example, Kipke and colleagues (1995c) employed a stratified probability sampling design to survey street youth in Los Angeles, California. They found three quarters of the youth surveyed (79%) reported having used alcohol at some time in their lives; of these youth, 50% had used alcohol during the week prior to assessment. Rates of lifetime illicit drug use were also found to be high, with methamphetamine or "speed" (62%), marijuana (55%), and crack cocaine (38%) being the most commonly used drugs. Using a risk/dependency scale developed by Gable (1993), it was determined that nearly 65% of the sample reported recent use (i.e., use within the past 30 days) of high

risk/high dependency drugs, 16% reported recent use of high risk/low dependency drugs, and 55% reported use of low risk/low dependency drugs. Thirty percent of the total sample reported having ever injected drugs; 58% of these youth reported having injected drugs within the previous 30 days.

In another recent study, systematic sampling methods were used to recruit samples of street youth in four United States cities: New York City, San Francisco, Los Angeles, and San Diego (Kipke et al., 1995a). Findings from this research revealed alarmingly high rates of lifetime and recent drug use, with rates and types of drugs varying across the four cities. Specifically, respondents on the West Coast (i.e., Los Angeles, San Francisco, and San Diego) were significantly more likely to report lifetime and recent use of "speed" as compared to respondents in New York City, while respondents in San Francisco were significantly more likely to report recent use of the "psychedelic" drugs, such as LSD, ecstasy, peyote, mushrooms, and opium.

While these studies have succeeded in characterizing the prevalence of lifetime and recent drug use among representative samples of street youth, little research has been conducted to evaluate severity of drug misuse or the prevalence of "substance abuse" disorders within this population. To date, only one study has systematically examined the prevalence of "substance abuse" disorders within a representative sample of runaway and homeless adolescents (Robertson, 1989). This study, conducted with youth ages 12 to 17 years, found that 48% of respondents met DSM-III criteria (American Psychiatric Association, 1980) for a diagnosis of "alcohol abuse," 39% met diagnostic criteria for "drug abuse," and 26% had diagnoses of both "alcohol and drug abuse." This study focused on the correlates of "alcohol abuse." The authors reported that respondents who were Caucasian and who reported a more chronic history of homelessness were significantly more likely to have an "alcohol abuse" disorder.

The purpose of the current study was to conduct epidemiologic research to estimate the prevalence of alcohol and other "drug abuse" disorders among runaway and homeless youth, and document variation by gender, age, ethnicity, age first left home, and length of time homeless. The present study adds to the existing literature by: (a) using systematic sampling methods to recruit youth from both service and natural "hang-out" sampling sites; (b) assessing "substance abuse" disorders according to DSM-III criteria; (c) surveying youth ranging in age from 13 to 23 years, thus permitting a comparison of the prevalence of abuse disorders among younger and older youth; and (d) examining the association between a diagnosis of a "substance abuse" disorder, length of time living on the streets, and age when respondents first left home.

METHODS

Setting, Sampling Design, and Recruitment Procedures

Youth were eligible to participate in the study if they were 13 to 23 years of age and homeless or at imminent risk for homelessness. Youth were considered homeless if their primary night residence was in a supervised public or private shelter, an institution that provides a temporary residence (e.g., halfway house, motel/hotel, boarding house, treatment facility, prison), or a public or private place not ordinarily used as a regular sleeping accommodation (e.g., on the street, in an abandoned building, park, abandoned car). Youth were considered to be at imminent risk for homelessness if they were temporarily and inadequately housed in a residence that was not their own (e.g., platonic friend's house or apartment).

Youth were recruited using systematic sampling methods in an effort to obtain a sample that was representative of the target population in the Hollywood area of Los Angeles, California. Based on an initial community assessment, two distinct yet similar sampling frames were developed, one for "fixed" or service sites (i.e., shelter and drop-in centers) and one for "natural" street sites (i.e., street corners or highly populated blocks) and "hang-outs" (e.g., parks, alleys, bars, fast-food restaurants, etc.). Survey research, field observations, and service provider census data suggested that sampling within the shelter and drop-in centers located within Hollywood would reach approximately half of the Hollywood runaway, homeless youth population. Thus, three shelters and six drop-in locations were selected for the fixed primary sampling units (PSUs), and 50% of the sample assignments were at these fixed sites. At each of the fixed PSUs, interviewer teams (consisting of 2 to 4 members) first reviewed the agency's sign-in roster to determine how many youth were in the agency. They then determined the sampling fraction (from a sampling fraction table) according to the number of potential participants. Using the sampling fraction and a predetermined random start number, youth were selected from the sign-in roster and approached by the interviewers.

Street-based sampling occurred along five major boulevards within a 12 square mile area of Hollywood. Along these boulevards, 73 street areas (divided into 3 block segments), corners and/or alleys, four parks, and three restaurants were identified as natural PSU's. At each of the natural PSUs, interviewer teams first determined the number of potentially eligible youth (i.e., along the street block segment, on the street corner, in the alley, or in a previously selected area of a park) and then determined the sampling fraction. Youth were then "counted out" and selected according to the sampling fraction and predetermined random start number.

The team of interviewers for the study were experienced data collectors and outreach workers who were integrated into the street and runaway, homeless youth populations in Hollywood. The demographic characteristics of the interviewers were similar to those of the target population; they ranged in age from 18 to 32 years and represented both genders and the three major ethnic categories of street youth in Los Angeles (i.e., African-American, Caucasian, and Latino). In addition to extensive training on the administration of the instrument, the interviewers were also instructed in the correct procedures for obtaining informed consent, maintaining confidentiality, reporting abuse, and providing referrals for services.

The interviewers approached potential subjects by delivering a brief script which introduced the interviewer and research study, and then requested permission to ask 8 questions to determine eligibility in exchange for $3.00 in bus tokens. The screening instrument assessed age, ethnicity, school attendance and grade level, places stayed during the last 12 months, usual sources of income, previous participation in the study, and willingness to participate in the interview. If eligible, youth were asked to participate in a structured interview which was conducted at a nearby coffee shop or fast-food restaurant (such patronage permitted the interview to occur in a safe, quiet setting). A meal worth approximately $10 was purchased for the youth which they ate during the course of the interview. Youth received $3.00 in bus tokens for completing the screening instrument and $10 in food vouchers (e.g., McDonalds) for completing the interview. The research received formal institutional review board approval, and all subjects signed an informed consent form prior to completing the screening and survey instruments.

During the period between July 1994 and September 1995 a total of 601 individuals were approached and asked to complete the screening interview. Among these youth, 17 individuals had been approached two or more times. Thus, the actual number of youth who were approached (only once) was 584. Among the 584 youth approached, a total of 29 (5%) individuals refused to be screened. Among the 555 youth who were screened, 26 (5%) were found to be ineligible to participate because of their age (5 were too young and 21 were too old), and 14 (3%) youth were ineligible because they did not meet the criteria for homelessness or imminent risk for homelessness. Among the remaining 515 eligible youth, 83 (16%) refused to participate in the study. Thus, the final sample consisted of 432 subjects, representing 84% of the eligible youth, 78% of the youth screened, and 74% of the youth approached.

Preliminary analyses were first calculated to test for demographic differences between the youth who refused to participate and those who completed the survey. Chi-square analyses were used to compare the interviewers reports of the gender, ethnicity, and age of the youth across participation status (par-

ticipant versus refusal). These analyses revealed that subjects who completed the survey were more likely to be in the over 19 age category than subjects who refused to participate (54 versus 41%, $p < .05$). Gender and ethnic composition did not differ across participation status.

Survey Instrument

All study participants were administered a 60–75 minute structured survey instrument developed to assess alcohol and other drug use, mental health, physical health, homelessness history, subsistence patterns, family and social history, residential status, HIV risk behaviors, criminal history, and victimization among runaway and homeless youth. Interview language and content comprehension were maximized through the use of focus groups with street youth and service providers when developing the survey and pilot testing of an earlier version of the survey with 20 street youth. The data presented here were obtained from the alcohol and other drug use section which included questions on alcohol and other drug use, tolerance, and dependence. Questions from the Substance Abuse Module (SAM; Robins et al., 1990) were used to identify respondents with a history of alcohol and other "drug abuse" or dependence based on DSM-III criteria. Using these questions, respondents were classified as having: 1) neither an abuse nor dependence diagnosis, 2) a diagnosis of abuse only, 3) a diagnosis of dependence only, or 4) a diagnosis of abuse and dependence. An *abuse* diagnosis was given to those respondents who reported evidence of both pathological use and impairment in social or occupation functioning due to use. A *dependence* diagnosis was given to those respondents who reported evidence of: 1) either tolerance or withdrawal, and 2) either pathological use or impairment in social or occupational functioning due to use. Respondents who met the criteria for diagnosis of abuse, dependence, or both were coded as having an *abuse disorder*. For the purpose of this research, two separate dichotomous variables were created, one to characterize an "alcohol abuse" disorder and one to characterize a "drug abuse" disorder.

Length of time homeless was assessed by asking participants to report the cumulative amount of time spent without a consistent rented room, apartment, or house. A "consistent" place was defined as a place where respondents had slept for 30 consecutive nights, regardless of who paid the rent, lease, or mortgage. Respondents were instructed to consider abandoned buildings, cars, shelters, and jails as examples of inconsistent places to stay.

Age at which the youth first left home was assessed by asking subjects to "think about the time you first remember leaving home either voluntarily or involuntarily for any length of time without your parents or other caretakers."

The participants were then asked to report how old they were when they first left home.

Data Analysis

First, univariate analyses were conducted to describe the study sample. Next, the binary "alcohol abuse" disorder and "drug abuse" disorder variables were created from the 4-level DSM-III criteria. Chi-square analyses were then used to examine the association between "alcohol abuse" disorder and "drug abuse" disorder. Next, the associations between each of the "substance abuse" disorder variables and the demographic variables of age, gender, and ethnicity were examined using logistic regression analyses. Separate models were calculated for "alcohol abuse" and "drug abuse" disorders. Logistic regression analysis was then used to examine the association between length of time homeless, age first left home, and each of the "substance abuse" disorder variables. Finally, all of the predictor variables were entered into multivariate logistic regression models to determine the extent to which each of the variables are associated with an "alcohol abuse" disorder and an illicit "drug abuse" disorder after adjusting for the influence of the other variables. All analyses were performed using the Statistical Analysis Software (SAS, 1989) for personal computers.

RESULTS

Sample Characteristics

As shown in Table 1, the majority of the respondents were male (66%) and Caucasian (51%). Ages ranged from 13 to 23, with the mean age being 19.0 years. Respondents reported an extensive history of homelessness, with 21% having been homeless for 3 or more years, 23% for 1 to 3 years, 25% for 3 months to 1 year, and 31% for less than 3 months. Over half the sample reported having left home the first time before the age of 15 (54%). As shown in Fig. 1, respondents reported using a variety of locations for shelter during the last 12 months.

"Substance Abuse" Disorder Diagnosis

Subjects were classified according to the 4-level DSM-III diagnosis schema. Regarding the "alcohol abuse" disorder classification, 18% of the sample met the criteria for "abuse" only, 5% met the criteria for "dependence" only, 32% met the criteria for both "abuse" and "dependence," and 45% did

Table 1.

Description of the Study Sample (N = 432)

Variable	*n*	%
Gender:		
Female	148	34
Male	284	66
Age:		
17 years or younger	108	25
18–19 years	148	34
20 years and older	174	41
Ethnicity:		
White	215	51
African-American	87	20
Latino	65	15
Other	59	14
Cumulative length of time homeless:		
0–3 months	129	31
> 3 months to 1 year	103	25
> 1 to 3 years	94	23
Over 3 years	87	21
Age first left home:		
12 years or younger	89	23
13–14 years	119	31
15–16 years	98	25
17 years and older	84	21

not show evidence of an "alcohol abuse" disorder. Regarding the "drug abuse" disorder classification, 12% of the sample met the criteria for "abuse" only, 9% met the criteria for "dependence" only, 39% met the criteria for both "abuse" and "dependence," and only 40% did not show evidence for a "drug abuse" disorder. Thus for both "alcohol abuse" disorders and "drug abuse" disorders, the majority of subjects who met the criteria for "abuse" also met the criteria for "dependence."

Next, we examined the association between "alcohol abuse" disorder and "drug abuse" disorder classifications. For each drug type (alcohol or illicit drugs), subjects who met DSM-III criteria for either "abuse," "dependence," or both were classified as positive, others were classified as negative. The two disorders were found to co-occur ($\chi^2 = 81.58$, $df = 1$, $p < .001$). Overall, only 29% of the sample did not meet DSM-III criteria for either an alcohol or a "drug abuse" disorder; 12% met the criteria for an "alcohol abuse" disorder only, 16% met the criteria for "drug abuse" disorder only, and 43% met the criteria for both an "alcohol and drug abuse" disorder.

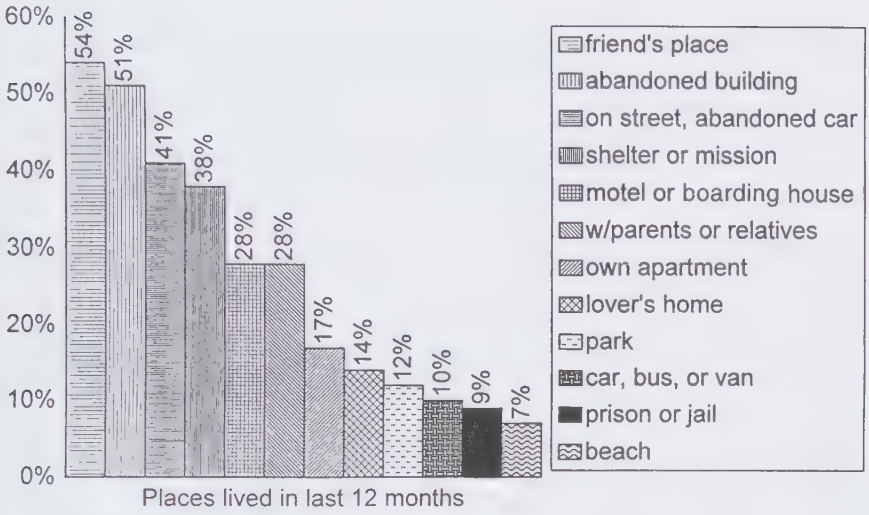

Fig. 1. Places where the subjects lived.

Demographic Variables and "Substance Abuse" Disorder Classification

Next, we examined the association between the "substance abuse" disorder classification and the demographic variables of gender, age, and ethnicity. Of the demographic variables examined, only ethnicity was found to be significantly associated with having a "substance abuse" disorder. African-American subjects were found to be significantly less likely than Caucasian subjects to report evidence of having either an "alcohol abuse" disorder or an illicit "drug abuse" disorder. As shown in Tables 2 and 3, these results remained significant after adjusting for the other demographic variables.

Length of Time Homeless and "Substance Abuse" Disorder Classification

The results from the univariate and multivariate logistic regression models predicting an "alcohol abuse" disorder or "drug abuse" disorder from length of time homeless are shown in Tables 2 and 3. Length of time homeless was positively associated with both risk of "alcohol abuse" disorder and risk of "drug abuse" disorder. Inclusion of the demographic variables and age first left home variable in the models did not substantially alter these associations.

Table 2.

Results from the Logistic Regression Analyses Predicting "Alcohol Abuse" Disorder from Length of Time Homeless and the Demographic Variables

	Disorder		Univariate		Multivariate	
	n	%	OR	95% CI	OR	95% CI
Gender:						
Female	78	54	1.00		1.00	
Male	156	56	1.12	0.75–1.67	1.58	0.96–2.57
Age:						
17 years or younger	61	58	1.00		1.00	
18–19 years	82	56	0.92	0.56–1.54	0.66	0.35–1.24
20 years and older	89	52	0.78	0.48–1.28	0.54	0.28–1.04
Ethnicity:						
White	136	65	1.00		1.00	
African-American	31	36	0.31	0.18–0.52**	0.39	0.21–0.70**
Latino	34	53	0.62	0.35–1.09	0.60	0.32–1.13
Other	27	47	0.47	0.26–0.85*	0.42	0.22–0.81*
Cumulative length of time homeless:						
0–3 months	55	43	1.00		1.00	
> 3 months to 1 year	59	59	1.91	1.12–3.25*	1.87	1.03–3.40*
> 1 to 3 years	62	67	2.66	1.52–4.63**	2.45	1.30–4.63**
Over 3 years	51	61	2.05	1.17–3.59*	1.58	0.82–3.04
Age first left home:						
12 years or younger	60	68	1.00		1.00	
13–14 years	66	57	0.63	0.35–1.12	0.62	0.33–1.14
15–16 years	53	56	0.59	0.32–1.08	0.57	0.30–1.09
17 years and older	41	49	0.45	0.24–0.83*	0.53	0.26–1.06

*$p < .05$; ** $p < .01$.

Age at which the youth first left home was found to be inversely associated with risk for either an alcohol or "drug abuse" disorder in the univariate models. However, this association was not found to be significant after length of time homeless was included in the model.

CONCLUSIONS AND RECOMMENDATIONS

It is important to note that this study has several limitations which should be considered when interpreting the results. First, the interview procedures relied entirely on participants' self-reports. Since alcohol and other drug use is illegal and often perceived as socially undesirable, these data may actually reflect underestimates of the true prevalence of these behaviors within this sample. Similarly, one could argue that a certain subpopulation of youth with

Table 3.

Results from the Logistic Regression Analyses Predicting "Drug Abuse" Disorder from Length of Time Homeless and the Demographic Variables

	Disorder		Univariate		Multivariate	
	n	%	OR	95% CI	OR	95% CI
Gender:						
Female	90	62	1.00		1.00	
Male	159	58	0.85	0.56–1.28	1.14	0.68–1.91
Age:						
17 years or younger	70	67	1.00		1.00	
18–19 years	83	58	0.69	0.41–1.17	0.53	0.27–1.03
20 years and older	95	56	0.64	0.39–1.07	0.59	0.29–1.19
Ethnicity:						
White	140	68	1.00		1.00	
African-American	32	37	0.28	0.16–0.47**	0.31	0.17–0.57**
Latino	40	63	0.77	0.43–1.39	0.87	0.44–1.69
Other	33	57	0.61	0.34–1.11	0.57	0.28–1.14
Cumulative length of time homeless:						
0–3 months	55	44	1.00		1.00	
> 3 months to 1 year	62	63	2.16	1.26–3.71**	2.75	1.45–5.14**
> 1 to 3 years	67	73	3.46	1.94–6.17**	4.15	2.11–8.18**
Over 3 years	60	72	3.37	1.86–6.11**	3.13	1.56–6.29**
Age first left home:						
12 years or younger	64	74	1.00		1.00	
13–14 years	72	63	0.62	0.34–1.13	0.65	0.34–1.25
15–16 years	58	62	0.59	0.32–1.24	0.60	0.30–1.19
17 years and older	40	48	0.33	0.18–0.64**	0.50	0.24–1.05

*$p < .05$; **$p < .01$.

"substance abuse" disorders may refuse to admit that they are experiencing consequences from their substance misuse, even to themselves. Therefore, it is plausible that the actual prevalence of "substance abuse" disorders may be higher than what was reported. However, assurances of confidentiality and the youths' sense of personal responsibility could have also resulted in accurate reporting. In fact, the prevalence of "substance abuse" disorders within this sample was found to be consistent with the results from previous research with younger samples of homeless youth (Robertson, 1989). Second, due to the cross-sectional nature of the data, the underlying causal patterns among these variables cannot be determined. Longitudinal research is therefore needed to more carefully evaluate the temporal relationship between onset of homelessness, drug use, and the onset of a "substance abuse" disorder. Third, although this sample is likely to be representative of the runaway, homeless

youth population in the Hollywood area of Los Angeles, the extent to which these findings can be generalized to runaway and homeless populations in other cities is unclear.

Despite these limitations, there were several significant findings from this research. Specifically, unlike the pattern of substance misuse observed in the general population (Kann et al., 1995), in the current study, age and gender were not found to be significantly associated with risk of having an alcohol or "drug abuse" disorder. These findings suggest that, among street youth, "substance abuse" disorders are extremely common across age and gender categories. Risk for reporting a "substance abuse" disorder, though was found to vary by ethnicity. Relative to Caucasian youth, African-American youth and youth who reported "Other" as their ethnic background were less likely to report symptoms of an "alcohol abuse" disorder, and African-American youth were less likely to report symptoms of a "drug abuse" disorder. These results are consistent with the findings reported by Robertson (1989). They are also consistent with other research suggesting that African-American homeless youth report lower levels of perceived peer pressure to use drugs as compared to their Caucasian and Latino peers (Kipke et al., 1995b).

Additionally, over two-thirds of the sample reported experiencing symptoms indicating the presence of a "substance abuse" disorder according to the DSM-III criteria. Furthermore, a significant association was found between "alcohol abuse" and "drug abuse" disorder classifications. In fact, among the youth who reported symptoms of a "substance abuse" disorder, the majority reported symptoms of both alcohol and "drug abuse" disorders. These results indicate that alcohol and other drug misuse is a pervasive and potentially debilitating problem among these youth, thus indicating the need for outreach strategies that help to effectively link these youth with comprehensive drug user treatment services.

Although risk for reporting either an alcohol or "drug abuse" disorder was not found to be positively associated with age at which youth first left home, the cumulative length of time a youth spent without a consistent place to live was found to be positively associated with the risk for a diagnosis with either disorder. This finding suggests that the youth who are most in need of help for an alcohol or other "drug abuse" disorder may be the youth who are the most difficult to reach given their more chronic pattern of homelessness. Furthermore, although causality cannot be inferred from this cross-sectional study, the significant association between "substance abuse" disorder classification and cumulative length of time homeless is consistent with the hypothesis that homeless youth with a "substance abuse" disorder may be at increased risk for becoming homeless adults.

Some communities have begun to mobilize to meet the service needs of runaway and homeless youth. For example, in the Hollywood area of Los Angeles, California a system of care has been developed by the Division of Adolescent Medicine, Childrens Hospital Los Angeles, in collaboration with over a dozen other youth-serving agencies in that community. This network of agencies has worked collaboratively to develop "a system of care" which provides youth with short-term crisis shelter, comprehensive medical and psychosocial care, and long-term shelter and case management. However, despite the apparent availability of services, previous research has shown that, among homeless youth in Hollywood with "substance abuse" disorders, only 15% used substance user services and 37% used youth shelters (Johnson et al., under review). Thus, it appears that although the need for substance user services is high and services exist, the level of utilization is quite low. There are at least two explanations for this disparity. First, it is likely that for some youth, substance use represents a means of coping with life on the street and is maintained as a form of self-medication (see Khantzian, 1985). Among these youth, treatment may be viewed as undesirable. Second, alcohol and other drug use may serve to further destabilize these youths' lives, making it more difficult for them to access or use services which could potentially help them transition off the streets. Special intervention efforts are therefore needed to identify, engage, and link substance using youth with residential stabilization and treatment services as well as other needed ancillary services such as life skills training, educational and vocational training, and placement assistance.

It is also likely that not all youth are prepared for treatment. Outreach may therefore be necessary to assess these youths' treatment "readiness." For some youth the intervention may require a "pretreatment" stage wherein the immediate crises are addressed through sheltering services and short-term detoxification. The goal at this phase of treatment would be to initiate engagement into a treatment readiness process. As youth progress to a stage where they are better prepared for treatment, other services will be needed including, but not limited to, counseling, psychiatric care, primary health care, and peer support groups. Clearly the need for such an array of services exists. The challenge is to increase the use of these services by those in greatest need with the goal being to ultimately help them transition off the streets and into more stable, healthy, and productive lives.

The extent to which existing intervention efforts are successful at transitioning youth into a treatment process needs to be evaluated. Assisting street youth to transition to a point where they are willing to seek help for a substance abuse disorder should be an explicit goal of services targeted to those youth.

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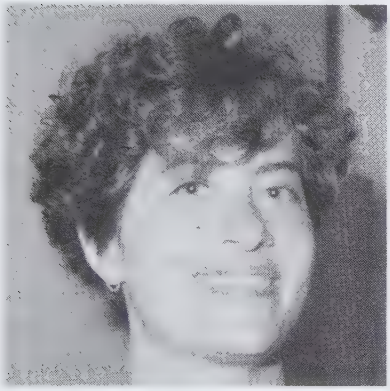

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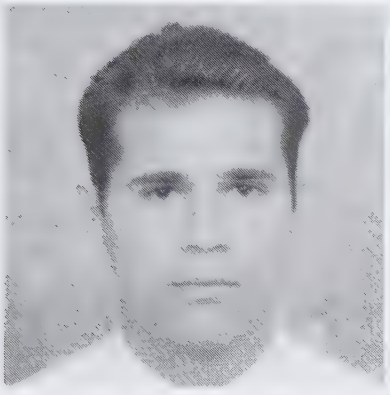

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Drug Use in Nepal: The View from the Street

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ABSTRACT

This study uses qualitative research techniques to examine heroin use in Nepal. It explores the life histories of 16 heroin users in Kathmandu, the country's capital, emphasizing those who are street children or who are otherwise displaced. The cases document that the initiation of use in Nepal is a complex process which includes: certain personality traits; an early history of culturally acceptable use of alcohol, tobacco, marijuana, or hashish; peer influence; and the specific social setting of users. Outside (i.e., foreign) influences are included in the mix, but never as a single determinant of drug use. Factors specific to the Nepali scene include the traditional association of forms of marijuana with certain religious contexts and the availability of heroin. An additional factor is the poverty of the urban setting. The approach in Nepal to dealing with drugs primarily involves a realization of the role played by the interaction between personality and social setting in the fullest meaning of that term. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Qualitative research; Heroin use; Nepal; Street children; Drug use context

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INTRODUCTION

The ethnography of drug use has a strong tradition to build on, a tradition that can be traced back to ancient history as Feldman and Aldrich have suggested (Feldman and Aldrich, 1990:12–22). An important part of that tradition is a focus on particular communities of drug users such as the recent study of the role of crack and its relationship to sex in the United States, *Crack Pipe as Pimp: An Ethnographic Investigation of Sex-for-Crack Exchanges* (Ratner, 1993). This study builds on that tradition but extends its application by looking into the cultural context of drug use, and above all heroin use, in Nepal, a country which has witnessed virtually no prior scientific studies of drug use (see Note 1). In keeping with the theme of this special issue, we focus further on a particular aspect of heroin use—among street children in the capital, Kathmandu.

Before examining this set of users, it is worthwhile to place drug use in Nepal in context. Nepal is not a major producer of drug crops as is, for example, the case with neighboring India, nor a major historical trafficking route, although in recent years there have been indications of increased movement of opiates through the country (see Note 2). Traditionally, there was widespread availability and use of marijuana (in leaf form and as hashish), some in connection with religious practices. Hinduism is the official religion of Nepal. Use of cannabis derivatives such as marijuana (locally referred to as ganja) and bhang (an infusion of cannabis) is often justified in connection with religious festivals because of the presumed predilection by one of principal figures of the Hindu pantheon, the God Shiva, for the drug (see Note 3).

The ease of availability of marijuana, a tolerant attitude toward drug use as well as an image of Nepal as Shangri-la, a mountain paradise, led to the growth of a drug-using "hippie" population in the country in the sixties and early seventies. In the seventies, stricter legislation and controls, as well as the social forces working within the hippie subculture, led to an end of this phenomenon, except for a few aging hangers-on. However, in the mid-seventies, cases of drug dependency on opiates, especially heroin, began to appear, growing in number according to observers over the past two decades.

Both official and unofficial estimates indicate that from virtually no cases in 1976, there were over 10,000 and even as high as 20,000 heroin addicts a decade later, concentrated in the Kathmandu valley (Kathmandu is the capital of Nepal, and the Kathmandu valley is a principal population center), but with cases also present in other urban areas. The existing legislation distinguishes between cannabis and other drugs in terms of the penalties provided. The idea of the legislation is to de-emphasize cannabis while continuing to express a

legal concern for other drugs such as heroin. However, there is only limited enforcement of that legislation (see Note 4).

The "drug problem," as noted above, has evolved over the past two decades. From a problem that centered on foreigners utilizing marijuana and psychedelic drugs, the major concern is now one of Nepalis, particularly young men and women, using heroin. The Government of Nepal had been reluctant as drug use evolved to recognize the existence of the drug problem and its indigenous character. However, by the middle of the 1980s, the government and the royal family began to express a interest and awareness of the serious nature of drug consumption in their country. Even so, that awareness was tempered by the persistence of an image of the problem as one that came from abroad. When the King of Nepal's brother HRH Prince Dhirendra Bir Bikran Shah opened the Seventh International Conference of Non-Government Organizations on Drug Dependence, held in Kathmandu in September, 1985, he remarked,

> Drug dependence is a fairly recent phenomena in this country, but one which has assumed alarming proportions not in terms of absolute numbers but in terms of the rate of growth in a short period. The uniqueness of this problem in Nepal has been that, despite the free availability of soft drugs and (their) limited use in society . . . (and on) . . . religious occasions, till comparatively recent times, addiction and dependency syndrome developed late . . . probably as an outcome of exposure to certain distorted elements of outside culture. [Seventh International Conference of Non-Government Organizations on Drug Dependence (1985), p. 3.]

STUDY DESIGN

This study originated in a concern with the drug-use(r)-associated problems facing Nepali youth on the part of Youth Vision, a Nepali nongovernment organization. The field work for the study took place in the period 1990–1992. The study was funded by a grant through the US Embassy from the State Department's Bureau of International Narcotics Matters. Technical assistance in the design of the study was provided by the Asia Regional Narcotics Education (RNE) Project of USAID as part of a larger effort to promote research on the nature and extent of drug use in Asia. (The RNE Project supported drug prevalence surveys in Thailand, the Philippines, and Sri Lanka.)

Initially, there were a total of 30 subjects, but full data were completed on only 16 of the subjects. Some of those initially included voluntarily dropped out of the study. Others were not followed up after initial contact because of

the limited time and resources available to the research team. (Funding for the study was fairly limited, and the research team worked on for a period on a voluntary basis.)

There was no assumption that the group would be statistically representative of the universe of heroin users in Kathmandu since the aim of the study was to portray the "heroin scene." The 16 subjects with full data represent a broad cross-section of the different elements that constitute that scene. The study employed a life history method that, through a series of interviews (a minimum of two, more if the subject was willing) with each subject, developed data on the personal history of each subject, his or her experiences with drug use, with drug-user treatment, current drug use, and current personal situation. The interviews were conducted in the native language of the speakers. Where interviews were conducted by nonnative speakers, one of the native speakers acted as interpreter.

Each subject was asked questions about his or her personal history, starting from early childhood, family background, relationships with other family members, education, employment, attitudes toward society, toward religion, toward other ethnic groups, interests and hobbies, and friends. With regard to drugs, each subject was asked about his or her personal history of use, the effects that had been felt, the relationship with other drug users, family patterns of drug use, drug use routine, modes of securing and financing drug use, consequences of drug use including relations with the law, and treatment of drug use.

In a study such as this, access is an important consideration. That access was secured by the research team because several of its members had a history of involvement in activities assisting the drug-using population of Kathmandu. This provided them both with the basic knowledge to understand the characteristics of the street environment and the drug scene in Kathmandu as well as initial credibility with the potential interviewees.

CHARACTERISTICS OF THE CASES

The 16 cases presented here reflect a cross-section of social characteristics and drug-use-associated problems found in the drug-user scene in Kathmandu. Those characteristics are discussed further below. To preserve the anonymity of the individuals studied, each individual is identified by consecutive letters of the alphabet (A–P) as well as by a term which characterizes his or her principal occupational activity. Table 1 summarizes selected characteristics of the cases in terms of their occupations, location in the social structure, and certain aspects of their drug use.

As Table 1 indicates, these drug users represent a wide variety of social situations and occupations. In a South Asian society such as Nepal which is multiethnic and multireligious, ethnicity, religion, and caste, related to the

Table 1.

Selected Background Characteristics of the Individuals Studied

ID	Occupation	Ethnicity (sex)	Age	Education[a]	Marital status[b]	Drug use	Treatment	Involvement with law	Current use
A	Dealer	Tibetan/Buddhist (male)	40	H.S.	M	Heroin, marijuana, hashish	7–9 times	Yes	Heroin
B	Social worker	Newar high caste (male)	34	H.S.	M	Heroin, marijuana, hashish, morphine, opium, tranquilizers	4	No	Drug-free
C	Drifter	Newar high caste (male)	31	H.S.	Sep	Heroin, marijuana	7	No	Marijuana alcohol
D	Priest	Brahman high caste (male)	24	E.S.	S	Heroin,	2	No	Tranquilizers
E	Laborer	Newar lower caste (male)	28	E.S.	M	Heroin	3+	No	Alcohol
F	Cassette packer	Newar lower caste (female)	27	None	M	Heroin, alcohol	None	No	Sedatives
G	Computer man	Minority religion (non-Hindu) (male)	27	College	S	Heroin, marijuana	None	No	Alcohol
H	Broker	Tibetan (male)	25	E.S.	S	Heroin, hashish	1	No	Heroin
I	Tailor	Low professional caste (male)	24	E.S.	S	Heroin, other opiates	5+	Yes	Alcohol

(*continued*)

Table 1. *Continued*

ID	Occupation	Ethnicity (sex)	Age	Education[a]	Marital status[b]	Drug use	Treatment	Involvement with law	Current use
J	Guide	High caste (male)	24	College	S	Heroin, marijuana, alcohol	2	No	Alcohol
K	Dealer II	High caste Newar (male)	25	Apprenticeship	C	Heroin, other opiates, prescription drugs	7	No	none
L	Biker	High caste Newar (male)	23	H.S.	S	Heroin, hashish	6	No	Alcohol
M	Bag-seller[c]	Hindu Gurung caste (male)	20	E.S.	M	Heroin, prescription drugs, hashish	None	Yes	Heroin
N	Baker	High caste Buddhist Newar (male)	20	H.S.	S	Heroin, marijuana, codeine	5+	Yes	Heroin
O	Kid-beggar	Tamang Buddhist (male)	18	E.S.	Sep	Heroin, tranquilizers	2	No	Alcohol
P	Kid[c]	Gurung (male)	14	E.S.	S	Heroin, marijuana, hashish	None	Yes	Heroin, presciption drugs

[a]Highest level of education achieved. E.S. is elementary school, H.S. is high school. College signifies postsecondary schooling.
[b]S is single, M is married, Sep is separated, and C is cohabitating.
[c]These two lived on the streets at the time of the study. The others lived in some sort of regular dwelling.

Hindu religion, represent important social markers. The group studied includes a member of the Hindu priestly caste (a Brahman) as well as other descendants of Indo-Aryan peoples who came up from the Indian subcontinent to form the modern Kingdom of Nepal. It includes Newars who are descendants of the indigenous inhabitants of the Kathmandu Valley. It also includes Tibetans from the north as well as Gurung, descended from hill people of west-central Nepal. The majority are Hindu, but some are Buddhist and one from a minority religion. (Nepal, as noted above, is officially a Hindu kingdom.) (For a discussion of Nepali peoples, see Bahadur Bista, 1987.)

Although the use of heroin is penalized by the law, only six of the 16 had been in any way involved with the law. Two of those were the most vulnerable, M and P, who lived on the street. None, however, had had long jail sentences.

DRUG CAREERS

Some of the defining characteristics of a drug user that have been examined in the literature (see Note 5) are patterns of initiating use, the types of substances used, the form and frequency of that use, the social context of use, and the outcomes of use—outcomes in terms of the impact on lifestyle as well as on the health and well being of the individual drug user. Outcomes also refer to the consequences of use—these may include going to jail, seeking treatment and rehabilitation and even, as was the case with at least one of the subjects of this study, death. While the size of the population studied is small, the life histories of each of the subjects can offer a wide variety of data on all of these topics. Presenting each person's story would stretch beyond the limits of this article. It would also step beyond the intention of this special issue—to examine populations that have been displaced. Thus, we shall try to focus in large part on issues that relate to the displaced populations, although where appropriate we shall refer to cases outside the set of those who can be classified as displaced.

Foreign Devils Did It to Us

Starting with one of the broader issues of the relationship between displaced populations and drug use, we have referred to the common perception in Nepal that the drug-user problem remains a problem resulting from the influence of foreigners. The political elite often expresses this view, as was noted above. The view is a common one in the history of drug use, not only in Nepal but all over the world. In Thailand it was the Chinese who were traditionally blamed for opium use. David Musto, in his history of drug use in the United States, *The American Disease*, comments that a US congressman

"Representative Porter in the 1920s denied any unusual appetite for narcotics in the United States, blaming our problem on the perfidy and greed of other nations" (Musto, 1987:248).

The cases in our study point to a far different picture of the origin of the drug-user(r) problem in Nepal. The set of 16 users included in this study display a variety of paths to heroin use. Some initiated use at a fairly early age (as young as 9), some at a far later age (as old as 28). The motivations they describe vary—curiosity, relationships with friends or relatives who were users, as a reaction to personal crises, as part of the context of a specific social setting. Many went through a gradual process of moving from one drug to another, while a few began directly with heroin. None of those interviewed had been drawn into drug use by foreigners, that is, as the consequence solely of direct contact with foreigners.

The individual we have called "the social worker" (Case B), demonstrates this variety of influences—starting with culturally acceptable patterns of use, having a peer group of drug users, moving from other drugs to an involvement with heroin. Because he was of the generation that grew up in Kathmandu when there were still "hippie" hangers-on, he had contact with them, but their role was most certainly not the deciding influence in his drug career. B began to use psychoactive substances as a child when his grandmother served him rice soaked in alcohol for breakfast. As a Newar, this constituted a traditional form of ingesting alcohol. B started smoking cigarettes when he was 14 years old. At the same age, he started smoking *ganja*, smoking it regularly with friends until he was around 18. He and his friends would sit around what is denoted as their "earth-room," a private smoking den—burning incense, listening to Western music and chatting, enjoying each other's company while passing around the "chilum," a cone-shaped pipe used for marijuana or hashish.

A similar pattern holds true for one of the displaced persons in the study, the individual we have called "the broker" (Case H). H demonstrates a common sequence—moving from other drugs to an involvement with heroin. H was born in Tibet but was taken to Nepal at the age of 3 when his family fled, apparently for political reasons. H left Kathmandu at the age of 10 to go to boarding school. His education was interrupted when his parents took him back to Tibet. He returned to Nepal after his father's death. For various reasons (the flight from Tibet, attendance at boarding school, the death of his father, and H's return to Kathmandu), H spent a good period of his adolescence separated from his family. As he explains the process, after living somewhat more than a year in Kathmandu, he was introduced to *charas* (hashish) by some Tibetan friends. (At the time he was unemployed.) For a few weeks he used both *charas* and *ganja* (marijuana) occasionally. He then observed this same group of friends using *brown sugar* [a form of heroin that is reputed in Kathmandu to have a higher degree of impurities (hence the brown color) and to originate

in Bihar state in northern India]. After more or less a month of observing, he asked those same friends to let him try the drug. His curiosity was aroused, he said, because one friend told him "If you take this, you fly in the sky; it gives a beautiful trip." He was interested enough to pay the equivalent of a couple of dollars to secure that first try. He took *brown sugar* by "chasing the dragon." This practice is common throughout South and Southeast Asia and consists of placing the drug on a piece of metal foil, heating it from below, and inhaling the smoke through a rolled piece of paper, often a currency note. One explanation for the name is that as the heroin is heated, one has to chase the smoke (the heroin dragon) across the foil so that it does not escape.

This first trip made him feel terrible. He remembers that he vomited and that his face and the rest of his body itched all over. But, he did, as his friends had promised, "feel nice." After this initiation he started using heroin every day, getting his dose free from friends for the first several weeks. He observed that in these early weeks, despite throwing up, he had "a nice feeling" from the use. He continued to use the drug, developing a means of securing the necessary cost of maintaining his supply.

Here again there is no "western devil" promoting drug use. H's initiation appears to be a function of the peer group he chose (Tibetans like himself), the information he received regarding the effects of the drug, and his curiosity. Again the availability of the drugs also contributed as did the perceived positive effects of the drug as weighed against the immediate negative consequences.

Another displaced individual, a street child (a person whose home is in the street as opposed to one who spends a considerable portion of time on the street, but still has a home), demonstrates the contribution made by social setting, reinforced by peer group behavior. The kid, Case P, initiated use extremely early in life, when he was 9 years old. P started using *ganja* and *charas* when he began work collecting and "recycling" garbage. Some of the friends he worked with "chased" *brown sugar*. They urged him to try because they said it would help to keep him warm through the cold nights. (P always slept in the open, on the streets.) They gave him some puffs of *brown sugar* which made him extremely thirsty and caused him to vomit. But despite this experience, he enjoyed the drug and continued using it—ending up after several years injecting rather than smoking. Here again, there is also the presence of the positive and negative effects of the drug itself.

The literature, it can be noted, suggests the importance of a sorting out process among certain groups by the drug of choice, a process that contributes in Nepal to the reinforcement of use in the case of street children. Ingram in his study of the US military (Ingram, 1984) points to the manner in which the type of drug defined the social group. As he states,

> Alcohol bonded small face-to-face groups, while drugs bonded larger social categories that cut across small groups and cliques. However, the contents of the social interaction, exchange of goods and services, exercise of status claims, and bids for social power were clearly present in both drug and alcohol patterns. (Ingram, 1984:166.)

In a similar vein, Alcaraz et al. (1995) in their study of Bolivian street children also noted that those they studied often sorted themselves out into groups whose membership could be defined by whether or not they used drugs as well as by the type of drugs that were used (for example, glue and other inhalants as opposed to cocaine paste).

The cases point to the need to see the initiation of use in Nepal as a complex process, a set of variables that lead to use rather than a single factor (for instance, the assumption that foreigners caused the drug problem in Nepal). No one variable determines. Variables that play a role include: an early history of culturally acceptable use of substances such as alcohol, tobacco, and in certain circumstances, marijuana or hashish; the influence of peers or significant others; and of the specific social setting in which they operate. There are times when outside (i.e., foreign) influences are included in the mix, but never as a single overarching determinant of drug use. A user may begin at an early age or far later in life. Peer groups and significant others do play a role, but so does curiosity, the interest in a new experience. The initial experience itself does not have to be an entirely enjoyable one. According to subjects in the study, that experience often brings physical discomfort, nausea, vomiting, and dizziness at the same time that it provides a "high." While all of this is not new to the literature on drug use, it is reaffirmed in this non-Western cultural context.

At the same time, there are some factors specific to the Nepali scene. For example, there is the traditional association of forms of marijuana with certain religious contexts as earlier noted in the case of the Hindu deity Shiva. [One case, C, used *ganja* for the first time at the age of 11 in the company of *saddhus* (holy men) at a Hindu temple.] This may assist in facilitating the entrance of some users into the drug scene. There is also the relative availability of heroin in Kathmandu which facilitates maintenance of a user's dependency.

Drug, Set and Setting

This examination of entrance into drug use points to the utility of seeing the process of drug use in Kathmandu in the framework provided by Zinberg's

drug, set (personality) and setting (1984:5). Following Zinberg's formulation, you need to understand the interaction of the pharmacological action of the specific drug or drugs being used, the attitudes and personality traits of the user, and the physical and social milieu of use in order to comprehend why a person uses a drug and how that drug affects a person.

In the case of heroin, the drug that is the focus of this study, the pharmacological effects include inducing a sense of euphoria, drowsiness, an insensitivity to pain, the possibilities of nausea, vomiting, and a dependency which is marked by withdrawal symptoms. In Nepal, heroin usually is available in two forms, *brown sugar*, which is usually smoked, and white heroin, which is injected.

In terms of personality traits, many of those in the study had low self-esteem, some were depressed. Many had little to show in the way of personal successes in school or in work and felt diminished as a consequence. Some came from dysfunctional families which again was reflected in their attitudes toward themselves. Some had broken with social taboos and felt rejection as a consequence—for example, by marrying a person not selected by their parents, a sharp break with cultural traditions.

Finally, in terms of social settings, many had peer groups which supported or promoted drug use (sometimes, in fact, where drug use was the focus of the group). Several were in precarious social situations, for example, maintaining themselves on the streets as scavengers of garbage, as beggars, brokers of illegal currency or of drugs.

Holding the type of drug constant (although there are certainly variations that resulted from whether or not heroin was inhaled or injected and differences as well in the quantities consumed), much of the variation among the cases was most certainly a function of the interaction between set and setting, that is, between personality traits of the individuals and the social and physical circumstances. Looking at several of the cases illustrates the terms of this interaction.

P, the kid, is certainly an individual who could call on very few resources. P at the age of 14 was effectively on his own, living on the streets of Kathmandu. P's father is one of the oldest heroin users in Kathmandu. P's stepmother does not want P to live with his father and her. P left his mother's house when he was 7. Sometimes he visits her, but never stays at her home. P's mother is remarried and her new husband does not like to have P "sticking around" according to P.

Thus, P is homeless, living on the streets of Kathmandu and generating income by begging and collecting garbage for recycling—plastic bags, metal scraps, and the like. About half of his daily income of around 80 to 100 rupees goes for drugs and remainder for meals and for watching videos.

P who, as noted earlier, injects heroin, prefers to do so with his friends in a deserted temple. P and his friends play the "in and out game" while injecting—drawing blood back into the syringe after the initial heroin dose is injected. The procedure is repeated as many as eight times and is a common practice among Nepali users who inject heroin. For the times when P does not have enough money to buy heroin, "somebody" will give him prescription drugs or he will buy the cotton wads used by his friends to prepare their heroin injections.

P has been robbed while he slept, arrested (four times) by the police, and been the victim of police extortions to avoid arrest and harassment. Despite these problems, P (the youngest of his group) indicated that he cherished his freedom. He was satisfied as well with the locality where he lived because of the cleanliness of the garbage. The area where he lives is one where there are a considerable amount of tourists who throw out their garbage in plastic bags, sometimes even throwing away items of considerable value. P and his friends defend that territory against other garbage collectors as their prized possession.

Thus, P combines a personal situation which has left him ostracized from his family with a desire for his personal freedom. He found a niche for himself which permits survival, provides a circle of friends, but is racked with risks, of arrest, of robbery, and of extortion. He clearly sits outside the normal social order. His displacement is absolute—after the study was completed he died, apparently of a heroin overdose.

H, the Tibetan discussed earlier, is also a street person. H is a broker, engaging in money changing and selling drugs on the street. In addition to the usual risks of street life and of drug use itself, H is at risk for HIV infection, a common feature of those studied given that 14 of the 16 at some time or another in their drug careers injected heroin. H started injecting heroin a year before the study, when he was 24. He devotes almost all of his income to buying heroin. While he and his friends receive clean needles and sterilized water from an American social worker, H says he and his friends "share syringes now and then." H knows that AIDS is a serious disease, connected with "having sex," but does not know any more about its transmission or prevention.

H's physical appearance is that of a street beggar. He does not appear to pay any attention to his physical well-being. His circle of friends are those linked to consuming heroin. His other significant set of relations are those he meets in the process of securing money for heroin. He does like to play with the children in his neighborhood and was observed teaching them games. He dreams of having his own business, an antique shop. He says that "if I leave this *brown sugar*, I think I have a chance. If I really leave, then my mother will give me money to open a shop."

His mother has made him the offer, but on the condition that he returns to his native Tibet. H does not believe that it will be possible for him to give up heroin while remaining in Nepal. "Here (in Kathmandu) I don't find any job; here, I don't have a good friend."

H's status on the street is a precarious one, but certainly not as great as that of P. He cannot find meaningful employment and friends he can count on. However, his prospects are greater because he can still draw on resources such as potential emotional and economic support from his family in Tibet. He has a broader range of choices, a function of his personal relationship with his family and the social opportunities that signifies. He also can generate greater financial resources in his role as "broker." In short, his life chances are greater than other denizens of the street.

Life with Heroin, Nepali Style

Beyond the lives of the socially marginal, it is worthwhile observing that, along lines suggested by Hanson et al. (1985), some heroin users in Nepal, much like some users in the inner cities of the United States as well as elsewhere in the society, can engage in conventional activities, managing their heroin use. Take as an example the case of J.

J has been able to maintain his daily use while functioning in a fairly active and responsible occupation—as a guide for mountain trekkers. J, who was 24 at the time of this study, had been dependent on heroin from the time he was 16.

He asserts that he had a heroin dependence he could control when needed. His approach while acting as a guide, he explained, was to use heroin once a day, in a dosage half his normal amount, taken covertly early in the morning. He would maintain this level of drug use while guiding hikers 6 to 8 hours a day for treks that lasted up to 6 weeks. In line with his concern not to display his dependency, he always dressed impeccably. He was determined not to show weakness to anybody. While J provided the study of evidence of his own self-doubt, he demonstrated a desire, carried out in his job, to maintain himself within the society's mainstream.

CONCLUSIONS

The study is an exploratory one. It opens up a need to further examine the complex, dynamic, multivariables associated with drug use and users—focusing on such issues as the relationship between the breakdown of traditional norms, of traditional family roles, and the reshaping of personal traits and social circumstances including the redefinition of the role of the family. It also

points to a cost of the poverty and marginality that permeates Kathmandu—the youngest subject and a casualty (see Postscript) was essentially a societal cast-off, outside his family, securing his livelihood in the most menial of forms—picking over society's garbage, whose closest circle of friends were involved as a group in drug use.

The study helps to dispel a myth—that the single causal factor that determines drug use is the presence of foreign influences. The cases point to a variety of interactions between social circumstances, personality, and the availability and impact of heroin and other drugs that result in the initiation of use and its continuation. There was a "hippie" subculture in Nepal, centered on Kathmandu, that no longer exists except in the case of a few aging hangers-on. That subculture was facilitated by easy and unsanctioned access to drugs. But the subjects in this study largely post-date the heyday of the subculture and have had little or no contact with its members. The "hippie" culture cannot be adjudged guilty as the single and sole cause of drug use among Nepalis.

This has important policy implications for the Nepali government as well as once more attacking what has been a persistent myth in the history of drug use in many parts of the world. The blame is placed on them, not on us. In the United States this has meant blaming the Chinese for opium, the Mexicans for marijuana, the African-Americans for cocaine (in the 1920s) (see Note 6). In Nepal, as we have noted, the foreign devil was the Western "hippie," but the data of this study document rather that there is a complex interaction in the case of heroin use between personality and social circumstance which takes advantage of availability. This means that to effectively deal with the problem(s) requires far more than condemning a factor that, in fact, is only a very small part (if it is any part at all) of the equation.

And as was pointed out, Nepal, like the inner cities of the United States, offers instances that demonstrate that heroin users are not "righteous dope fiends" but individuals who can seek to establish or reestablish meaningful relationships in their lives (H with his family), hold gainful employment and manage their drug use (the case of J).

As the literature repeatedly points out, the approach that needs to be taken in Nepal as elsewhere to deal with the drug-use(r)-associated issues involves a realization of its complexity, of the interaction above all between personality and social setting, understanding that social setting involves in and of itself an intricate relationship between political, social, and economic factors that set limits on the life chances of drug users. And as Wayne Weibel has suggested, the value added of this sort of qualitative research, which can reach displaced or hidden populations such as users in the street, is that it "is often the only means available for gathering sensitive and valid data from otherwise

elusive populations of substance abusers" (Weibel, 1990:5). And the picture that can be painted through such qualitative tools can provide insights regarding the relationships that exist and which can be the groundwork for future research.

POSTSCRIPT

It is incumbent on researchers of drug use to remember the very human dimension of what they do. That dimension is even more evident when the work is ethnographic. Two tragic events underscored that dimension for the researchers involved in this study.

Three months after the last interview with C, he died of a heroin overdose. Four months after the last interview with P, the youngest subject in the study, he also died of a heroin overdose. We were told that both overdoses were accidental. C has a wife and children and other family members who mourn him. There will not be many people apart from his gang who will remember P, let alone grieve for him. But he will be missed by his gang and by the members of this research team. We are grateful to both C and P for their willingness to share their concerns and their happiness, however small. May their souls find eternal peace.

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NOTES

1. There have been several quantitative studies of drug use that have focused on Nepali high school students as well as broad discussions of the sociological concomitants of drug use, but the study reported here is the first ethnographic study directly focusing on drug use. As a counterpart to the ethnographic study reported in this article, the US Embassy, with technical assistance from the United States Agency for International Development (USAID) Asia Regional Narcotics Education project, also supported a survey of drug use among students (Bhandari and Subba, 1992).
2. The Bureau of International Narcotics Matters, *International Narcotics Control Report* (Department of State, Washington, D.C., April 1994) notes that Nepal is "an attractive alternative trafficking route" (p. 237). The same report notes that there is no evidence of any significant Nepalese opiate production. This report is commonly referred to as the INCSR.
3. See Spencer and Navaratnam (1981:9) and Rubin and Comitas (1975) which refer to the cult of Shiva and its relationship to the use of cannabis. As Rubin notes "Cannabis is used in worship and in offerings made on the fulfillment of vows and *bhang* (an infusion of cannabis) is customarily served at weddings and religious festivals" (1975:17).
4. The data is this paragraph are based on the author's interviews in 1987 with officials of the Nepali government as well as local observers of the Nepali drug scene. See J. M. Jutkowitz, *Asia Regional Narcotics Awareness Survey*, (Arlington, VA: Development Associates, 1987) Ch. IV. The 1994 INCSR (see Note 2) reports a total of 25,000 users in the country, although this represents an estimate which does not result from national prevalence studies.
5. In discussing heroin, Robins writes about how a user initiates use, the frequency and amount of use, and the physical and social problems that seem to result from use in defining what he refers to as "addict careers" (1979:325). A review of such ethnographic studies as Hanson et al. (1985) or Feldman et al. (1990) shows an attention to these sorts of questions as well as others related to the particular type of drug and its specific cultural setting.
6. For a discussion of the racial stereotyping of users of various drugs, see Musto (1987). Musto writes about the myths of the relationship between African-Americans and cocaine use (pp. 7–8), Chinese and opium use (pp. 3–6), and Mexicans and marijuana use (p. 219).

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Hans Spielmann is an advisor to the United Nations Drug Control program where he is currently working on drug problems in Afghanistan. He has undertaken international research on the production, trade, and consumption of drugs in South and Southeast Asia, carrying research and providing technical assistance to national programs in Thailand, Pakistan, Nepal, India, and elsewhere in the region. Dr. Spielmann designed the protocols for the study, and he participated in the fieldwork and write-up of the initial results.

Ulrich Koehler was the drug prevention specialist of the United Mission to Nepal, an ecumenical effort to provide external support for social welfare, education, and other social concerns. He helped to establish drug prevention activities by assisting Nepali nongovernment programs in developing their programs. Mr. Koehler was instrumental in organizing this study and partici-

pated in the fieldwork and write-up of the initial results. He is currently working as a drug prevention specialist in the United Kingdom as well as a consultant to the United Nations.

Jagdish Lohani and **Anil Pande** were two of the founders of Youth Vision, a Nepali nongovernment organization that undertook programs of drug prevention, focused in large part on youth. Their organization provided the institutional framework for the study. Both Mr. Lohani and Mr. Pande were active in making the necessary contacts for the study and in carrying out the fieldwork.

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Available Resources for Investigating Substance Use among Homeless, Immigrant, and Refugee Populations

Compiled by Timothy P. Johnson

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In addition to the literature reviewed in the eight papers included in this special issue, this section provides a listing of agencies and organizations that may provide information useful in researching questions related to substance use and misuse among displaced persons. Many of these organizations maintain internet web sites that can provide immediate access to a variety of materials and, in many cases, linkage to other relevant organizations and resources. A web site has also been initiated as a resource dedicated specifically to addressing addiction issues among displaced peoples (available at the following address: http://www.srl.uic.edu/RSUADP).

Asian Research Centre for Migration
Institute of Asian Studies
Chulalongkorn University
7th floor, Prajadipok-Rampai Panee Bldg.
Phyathai Road, Bangkok 10330, Thailand.
Telephone: 66-2-218-7462
FAX: 66-2-255-1124
Internet e-mail: fiassct@chulkn.car.chula.ac.th
Internet web site: http://www.chula.edu/institute/arcm/main.htm

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Bureau of the Census
Washington, D.C. 20233, USA.
Telephone: 301-457-4100
FAX: 301-457-4714
Internet e-mail: webmaster@census.gov
Internet web site: http://www.census.gov

Canadian Centre on Substance Abuse
National Clearinghouse on Substance Abuse
75 Albert Street, Suite 300
Ottawa, ON K1P 5E7, Canada.
Telephone: 613-235-4048
Fax: 613-235-8101
Internet web site: http://www.ccsa.ca

Center for Migration Studies of New York, Inc.
209 Flagg Place Staten Island, NY 10304-1199, USA.
Telephone: 718-351-8800
FAX: 718-667-4598
Internet web site: http://cmsny.org
Internet e-mail: 718-667-4598

Centre for Immigration and Multicultural Studies
Australian National University
Canberra, Australia.
Internet web site: http://coombs.anu.edu.au/specialproj/cims/cimshomepage.html

Center for Refugee Studies
Suite 322, York Lanes, 4700 Keele Street
York University
North York, Ontario M3J 1P3, Canada.
Internet web site: http://www.yorku.ca/research/crs

Centre for Research in International Migration and Ethnic Relations
Stockholm University
S-10691 Stockholm, Sweden.
Telephone: 46-8-16-2264
FAX: 46-8-15-6720
Internet e-mail: ceifo.editor@ceifo.su.se
Internet web site: http://ceifo.su.se

European Research Centre on Migration and Ethnic Relations
Virtual Library on Migration and Ethnic Relations
P.O. Box 80.140, 3584 CS Utrecht, The Netherlands.
Telephone: 31-30-539-220
FAX: 31-30-539-280
Internet e-mail: ercomer@fsw.ruu.nl
Internet web site: http://www.ruu.nl/ercomer/wwwv1/wwwv1mer.hml

Immigrant-Institutet
The Swedish Immigrant Institute
Katrinedalsgatan 43, S-504 51 BORAS, Sweden.
Telephone: 46-(0)33-13-60-70
FAX: 46-(0)33-13-60-75
Internet e-mail: migrant@immi.se
Internet web site: http://www.algonet.se/~migrant

Institute for Migration and Ethnic Studies
University of Amsterdam
Rokin 84, 1012 KX Amsterdam, The Netherlands.
Internet web site: http://albion.geog.ucl.ac.uk/~hprophet/imes.html

Interagency Council on the Homeless
451 Seventh Street, SW, Suite 7274, Washington, D.C. 20410, USA.
Telephone: 202-708-1480
FAX: 202-708-3672

International Center for Migration Policy Development
Mollwaldplatz 4, A1040 Vienna, Austria.
Telephone: 43-1-504-46-4677
FAX: 43-1-504-46-7775
Internet e-mail: icmpd@site130.ping.at

International Council on Alcohol and Addictions
Case postale 189, 1001 Lausanne, Switzerland.
Telephone: 41-21-320-4865
FAX: 41-21-320-9817
Internet e-mail: icaa@ping.ch
Internet web site: http://www.who.ch/programmes/ina/ngo/ngo-5.5htm

International Organization for Migration
17 route des Morillons, P.O. Box 71, CH-1211 Geneva 19, Switzerland.
Telephone: 41-22-717-9111
FAX: 41-22-798-6150
Internet e-mail: telex@geneva.iom.ch
Internet web site: http://.iom.ch

Migration Dialogue
1044 Engle Place, Davis, CA 95616, USA.
Telephone: 916-752-1530
FAX: 916-758-4928
Internet e-mail: migrant@primal.ucdavis.edu
Internet web page: http://migration.ucdavis.edu

Migration Research Unit
University College
London, England.
Internet web site: http://albion.geog.ucl.ac.uk/~hprophet/

National Alliance to End Homelessness
1518 K Street, NW, Suite 206, Washington, D.C. 20005, USA.
Telephone: 202-638-1526
FAX: 202-638-4664
Internet e-mail: naeh@ari.net

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345, Rockville, MD 20847-2345, USA.
Telephone: 1-800-729-6686
FAX: 301-468-6433
Internet web site: http://www.health.org

National Coalition for the Homeless
1612 K St. NW #1004, Washington, D.C. 20006, USA.
Telephone: 202-775-1322
FAX: 202-775-1316
Internet web site: http://www.nch.ari.net

National Health Care for the Homeless Council
P.O. Box 68019, Nashville, TN 37206-9019, USA.
Telephone: 615-226-2292
FAX: 615-226-1656

National Institute on Alcohol Abuse and Alcoholism
Suite 400/6000 Executive Building, Mail Stop Code 7003, Bethesda, MD 20892-7003, USA.
Telephone: 301-443-3885
FAX: 301-443-7043
Internet web site: http://www.niaaa.nih.gov

National Institute on Drug Abuse
5600 Fishers Lane, Rockville, MD 20857, USA.
Telephone: 301-443-4577, 800-662-4357
FAX: 301-443-9127
Internet web site: http://www.nida.nih.gov

Refugee Policy Group
1424 16th Street, NW, Suite 401, Washington, D.C. 20036, USA.
Telephone: 202-387-3015
FAX: 202-667-5034

Refugee Studies Center
330 Hubert H. Humphrey Center
301 19th Avenue South
University of Minnesota
Minneapolis, MN 55455, USA.
FAX: 612-626-0273
Internet e-mail: refugee@maroon.tc.umn.edu
Internet web site: http://www.isp.acad.umn.edu/homeisp/rsc/res.html

Refugees International
21 Dupont Circle, NW, Washington, D.C. 20036, USA.
Telephone: 202-828-0110
FAX: 202-828-0819
Internet e-mail: ri@clark.net
Internet web site: http://www.clark.net/pub/ri

Refugees Studies Programme
University of Oxford
International Development Centre
Queen Elizabeth House, 21 St. Giles, Oxford, England OX1 3LA, UK.
Telephone: 44-1865-270-722
FAX: 44-1865-270-721
Interenet e-mail: rsp@qeh.ox.ac.uk

Scalabrini Migration Center
P.O. Box 10541, Broadway Centrum-Aurora Blvd., Quezon City 1113, Philippines.
Telephone: 02-787071
FAX: 02-721-4296
Internet e-mail: smc@mnl.sequel.net
Internet web site: http://www.sequel.net/~smc

Substance Abuse and Mental Health Services Administration
Room 12-105 Parkland Building
5600 Fishers Lane, Rockville, MD 20857, USA.
Telephone: 301-443-4795
FAX: 301-443-0284
Internet web site: http://www.samhsa.gov

United Nations High Commissioner for Refugees
1775 K Street, NW, #300, Washington, D.C. 20006, USA.
Telephone: 202-296-5191
FAX: 202-296-5660
E-mail: usawa@unhcr.ch

United Nations High Commissioner for Refugees
Centre for Documentation and Research
Case Postale 2500, CH-1211 Geneva Depot 2, Switzerland.
Telephone: 41-22-738-8169
FAX: 41-22-739-7367
E-mail: cdr@unhcr.ch
Internet web site: http://www.unicc.org/unhcrcdr

United States Committee for Refugees
1717 Massachusetts Ave., NW, Suite 701, Washington, D.C. 20036, USA.
Telephone: 202-347-3507
FAX: 202-347-3418
Internet e-mail: uscr@irsa-uscr.org
Internet web site: http://www.irsa-uscr.org

World Health Organization
Ch-1211 Geneva 27, Switzerland.
Telephone: 41-22-791-2111
FAX: 41-22-791-0746
Internet web site: http://www.who.ch

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Glossary

Acculturation - The changes that take place to the cultures of migrant groups as a result of contact with other cultures.

Alcoholic beverages - Includes beer, wine, and liquor

Alienation - Term used by Marx to mean the workers' loss of control of the nature of the labor task and over the products of their labor. Now usually used to convey a sense of powerlessness, disengagement, and disaffection among vulnerable groups.

Amphetamines - Includes Benzedrine, Dexedrine, Methedrine, Desbutal, Desoxyn, Dexamyl, and Daprisal (a combination of amphetamine and barbiturate) being used for nonmedical purposes.

Any drug - Includes any reported use of nonalcoholic drugs, including cocaine, heroin, marijuana, hallucinogens, sedatives, stimulants, or tranquilizers.

At-risk homeless - Precariously or marginally housed persons with only a tenuous or very temporary claim to conventional housing.

Bhang - An infusion of marijuana, often used in religious ceremonies, such as in celebrating the fulfillment of a vow. In Nepal, Bhang is associated with the Hindu deity Shiva.

Blaka Watra - Example of a low-threshold project in the city of Amsterdam. The target group consists of "elderly" (middle-aged) immigrants from Suriname and the Dutch Antilles with a long "drug career" who have gradually become socially isolated. The type of basic aid and services given (e.g., inexpensive meals, free washing accommodation, clothes exchange, health checkup and consultation) can be described as secondary prevention or harm reduction. The clients, called "visitors," might engage in recreational and sporting activities. The Surinamese words *Blaka Watra* are being associated with "rest, recreation, and healing power."

CAD - Consultation Bureau (Center) for Alcohol and Drugs. Specialized "outpatient" services in the Netherlands for people with substance-use-associated or addiction problems. This type of aid originated at the beginning of the 20th century and was directed at people with alcohol-use-associated

problems. In the 1970s the scope broadened to drug-use-associated problems, including tranquilizers, and more recently to gambling problems. Access, consultation, and therapy are free because the CADs are financed by the general fund.

Cannabis psychosis - Or Cannabis Delusional Disorder (DSM-III-R 292.11), is an organic psychotic disorder occurring after the consumption of cannabis.

Chaos theory - A branch of mathematics concerned with the study of complex systems. Chaos theory can be used to explain the unpredictable behavior that arises in deterministic systems because of sensitivity to initial conditions. The example that is always used is the possibility of a butterfly flapping its wings in the Amazon causing a hurricane in North America some weeks later. Beneath what appear to be random and chaotic events, like the occurrence of hurricanes, a form of order can be discerned.

Children *in* and *of* the street - A distinction first noted by UNICEF that separates street children into two groups, those who work *in* the streets with a parent or relative and those *of* the street who actually live there on their own.

Chilum - In Nepal, a cone-shaped clay pipe used to smoke marijuana and hashish.

Cocaine - In any form, including "crack" or "rock" cocaine, for nonmedical reasons.

Culture - The values, norms, and material goods characteristic of a given group. Values are abstract ideas about what is desirable or undesirable, good or bad, while norms are rules or principles that people are expected to observe.

Culture shock - The short-term psychological consequences of exposure to unfamiliar environments.

Deterministic model - A mathematical model in which the parameters and variables are not subject to random fluctuations, so that the system is at any time entirely defined by the initial conditions chosen.

Disaffiliation - Isolation of withdrawal from social networks or larger social institutions; general withdrawal from society.

Drinking culture - The ideas about the nature and value of beverage alcohol and the norms or rituals governing alcohol consumption that are observed within a given group.

Emiliehoeve - The first therapeutic community for drug addicts in the Netherlands, founded in 1972. The first years of the *Emiliehoeve* were quite controversial because of the (change in) approaches and methods. This "addiction clinic" is an example of a high-threshold institution. The psy-

chiatrist Martien Kooyman has been one of the leading figures in the *Emiliehoeve*. He has written the book *The Therapeutic Community for Addicts*, an authoritative study based on his own experiences and research.

Employment-based immigrants - Individuals granted visas for United States employment in job areas in which a labor shortage exists.

Endemic - Levels of infection which do not exhibit wide fluctuations over time in a given location.

Epidemiology - The study of the distribution and determinants of diseases in specified populations.

Ethnic minorities - An ethnic group which is in the minority within a given community. However, like the related term *minority group*, it usually implies more than being a minority in the statistical sense. Members of minority groups are usually disadvantaged as a result of discrimination, have a sense of group solidarity, and are usually physically and socially isolated from the larger community.

Ethnicity - The cultural practices and outlooks that distinguish a given community.

Etiology - (The study of) the causes of disease.

Family-based immigrants - Individuals who come to the United States to be reunited with family members who have become permanent residents or citizens of the United States.

Ganja - The Indian subcontinent's general term for marijuana.

"Heavy" use - Daily use or the consumption of at least six drinks per week or having used any drug at least six times per week.

Heroin - Includes heroin, morphine, opium, and other heroin-like drugs.

High risk drinking - A level of alcohol consumption which substantially raises the risk of harm. Defined as weekly consumption of over 35 British units for women and 50 units for men. One unit is equivalent to 8 g pure alcohol.

Hispanic - Latino, including Hispanic.

Homelessness - The lack of a permanent abode or residence. Can refer to adults who reside in shelters, in public locations such as streets or alleys, or to those in temporarily "doubled up" situations with friends and family.

IMC - Intercultural Motivation Center. A small inpatient institution, exclusively for "allochtonous" male addicts, which is part of the Jellinek Center in Amsterdam. The 12-week program aims to bridge the gap between the street and the "addiction clinic." However, these clients experience the approaches and methods in the main "addiction clinics" as predominantly "White."

Institutional racism - Whereas racism involves the exercise of prejudice by

individuals, institutional racism concerns the way in which organizational practices may disadvantage minority groups. It involves policies and procedures that ignore or reject ethnic minority values and lifestyles, or ideas about illness and health, or about the social use of substances because of the assumption that the dominant group's ways are "obviously" so much better, more civilized, more scientific.

Integration policy - This term, introduced by the Dutch Government in the early 1990s, reflects the idea that the social integration of minority communities and their members is a process of *mutual* acceptance, requiring effort *both* on the part of the newcomers and that of the society into which they are seeking to integrate themselves.

Junkiebond - A kind of union for drug users in the Netherlands, set up by a group of concerned heroin users in the early 1980s. Their starting point is to look after the interests of (hard) drug users. The *Junkiebond*, in Amsterdam known as MDHG, has contributed significantly to the development of a policy, both on a national and local level, that is aimed at the reduction of health risks, e.g., needle and syringe exchange, and the improvement of the drug user's quality of life. A periodical and other publications are being issued.

Khat (qat) - Traditional "drug" from the Middle East and Eastern Africa, stemming from the 3–6 meters high khat shrub. The fresh leaves and tender stems are chewed, retained in the mouth as a ball, and slowly moved around and chewed some more to release the active agent, cathinone or cathine, which is slightly stimulating.

Literal homeless - Individuals who lack a permanent and regular residence within a conventional dwelling unit.

Low threshold - Translation for the commonly used Dutch term *laagdrempelig*. It refers to a doorstep or barrier that one has to pass or overtake to enter a building or institution. An institution or organization with a low threshold is easy of access, with little practical or psychological barriers for a person (i.e., patient or client) to enter or get in touch with. Opposite of high threshold.

LSD - In any form, including "acid," "the cube," "blue cheer," "dots," etc.

Marijuana - Includes marijuana, hash, or hash oil.

Market children - A common term for children who work in or around the street markets in cities such as Tegucigalpa, Honduras. These children often work with a parent of relative to supplement the family income and/or care for young siblings.

Methadone bus - In major Dutch cities the phenomenon of the methadone bus has been known since the end of the 1970s. The advantage of a low-threshold methadone maintenance program from a mobile bus is that it

does not cause any great annoyance to people in a specific area. This is why the optimal capacity of such a dispensing program is 20–25 clients. The bus has a number of fixed stops in town, at specified times, for clients to receive their methadone. Liquid methadone must be used immediately on the spot. The program is only open to registered clients on a regular basis after central intake and selection. Methadone is not given to unknown transients. The methadone bus has roughly the appearance of a normal bus, but the inside has been designed like a tiny health center. There is usually running water, heating, a lavatory, a kitchenette, and a corner where one can wait, talk, and drink coffee. Dealing, taking drugs, or behaving aggressively is not tolerated. In addition to the bus driver, who sometimes plays the role of security person, the crew often consists of a nurse and a social worker. If necessary, they can make a referral to an outpatient clinic for appointment with a physician or social worker. In the second half of the 1980s it was decided to make the exchange of needles and syringes available in order to contain the spread of AIDS. A bus program has advantages over an immobile program in a health center of clinic. The bus can reach people in certain neighborhoods who are otherwise hard to contact. The number of clients in a specific location can be kept small to prevent fringe crimes. The expenses of a mobile bus are less than for immobile property, especially in more prosperous areas.

Migration stress - A generic term for the numerous stresses experienced during the process of migration. In addition to culture shock, these include the disruption of family and social support networks, loneliness, problems finding accommodation and employment, and changes to diet, costume, and climate.

NEVIV - National umbrella organization of the Dutch CADs and other specialized relief organizations, such as the inpatient "addiction clinics." It is located in the city of Utrecht, in the middle of the country.

Opium Act - The first international conferences on narcotic drugs, known as the Opium Commission, brought together 13 nations at Shanghai in 1909. The deliberations led to the signing of the first international drug-control treaty, the Hague Convention of 1912. After the Hague Convention, the first Dutch Opium Act was enacted in 1919. This law has been changed a number of times, the most recent alteration being in 1976, when a distinction was made in the law between high-risk drugs (such as heroin, cocaine, amphetamines, and LSD) and drugs with a lower risk (namely the "traditional hemp products" hashish and marijuana.

Parents of Drug Addicts - Foundation in the Netherlands which was set up by parents of heroin addicts in the early 1980s. Their point of reference was the bad relationship they had with the counselors and therapists of the

CADs and other institutions who had contact with their addicted children. The parents were angry because they were denied information about the whereabouts and health status of their children. There was also controversy about the family therapy model that had been introduced by Duncan Stanton and Thomas Todd. Today, different forms of cooperation between the Foundation and the professional organizations are laid down in a covenant.

Pathogenicity - The degree to which a pathogen debilitates its host.

PCP - In any form - Including "angel dust," "crystal," etc.

Prescription drugs - Includes any reported use of tranquilizers (Valium, Librium, etc.) and sleeping pills (Quaaludes, Tuinal, Seconal, etc.) for nonmedical purposes.

Proyecto Alternativas - An outreach program for street children located in Tegucigalpa, Honduras. It is supported by local and international nongovernmental organizations and the School of Public Health at Tulane University, with whom the director is affiliated. It is unique in that it offers primary health care and education in good nutrition and sanitation practices.

Race - Physical differences which are used to categorize large numbers of people. Race is no longer regarded as a particularly useful scientific category, as the genetic variation within racial groups is now known to be greater than the variation between groups. Nevertheless, the concept of race remains an influential one in many societies.

Racism - Attributing superiority or inferiority to populations that share certain physically inherited characteristics.

Refugees - Individuals unable or unwilling to return to their native country because of persecution or a well-founded fear of persecution.

Resistolero - A name applied to glue-sniffing street children (usually boys) in Tegucigalpa, Honduras. It refers to *Resistol*, the brand name of a popular shoe glue that is most commonly used as an inhalant by these children.

Saddhus - Hindu holy men, individuals who dedicate their lives to the service of Hindu deities.

Social network - The group of people, such as friends and family members, with whom a focal individual maintains contact and has some form of social bond.

Southeast Asian - People from Cambodia, Laos, and Vietnam.

Standardised Mortality Ratio - In the UK the Standardised Mortality Ratio (SMR) is the preferred method for adjusting for age and sex when comparing populations. It does not require age-specific death rates for each population, avoids the distortions inherent in direct standardization when age distributions vary markedly, and is less affected by small numbers of

deaths in the age-specific immigrant populations.

Street children - Any girl or boy . . . for whom the street (in the widest sense of the word, including unoccupied dwellings, wasteland, etc.) has become his or her abode and/or source of livelihood; and who is inadequately protected, supervised, or directed by responsible adults.

Street educator - A man or woman who works with street children as part of an outreach program. The program may be supported by government organizations, local or international, to provide aid and education for children who must work and/or live on the streets.

Street kids - A common term for children who spend most of their time on the streets in cities such as Tegucigalpa, Honduras. They are often runaway, abandoned, or orphaned children who beg, steal, or do odd jobs to support themselves. They are the *typical* street children referred to in the media.

Substance misuse - The use of either legal or illegal drugs despite their detrimental effects on physical, emotional, and social health, often to the point of addiction.

Substance use - A general term which describes taking or using alcohol/drugs of any kind.

Toluene (methyl benzene) - A solvent that is widely used as a paint thinner, cleaning and drying agent, and as the major component in many paints, lacquers, glues and adhesives, inks, and cleaning liquids. Substances containing toluene are reported by researchers on inhalants to have, perhaps, the highest potential for abuse.

Undocumented aliens - Illegal immigrants to the United States.

Unmet treatment needs - Individuals identified as having a need for treatment who report having never received either inpatient or outpatient care.

Vulnerability - Extreme levels of poverty and need that may put an individual at risk for homelessness. It tends to be characterized by long periods of unemployment or partial employment and dependence on public and/or private charitable programs.

XTC or ecstasy - Popular name for a substance from the class of "Phenylalkylamine Psychedelics," also known as MDMA. The substance is popular among adolescents in Europe because of its stimulating and slightly psychedelic properties. It is usually taken in the context of the music and dance culture ("house parties" or "raves").

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International Abstracts

SUBSTANCE USE AMONG STREET CHILDREN IN HONDURAS

Martha Caroline Whitworth Wittig, James D. Wright, and Donald C. Kaminsky [*Substance Use Misuse*, 32(7&8), 805–827 (1997)]

The hypothesis that drug use among Honduran street children is a function of developmental social isolation from cultural and structural influences is examined. Data from 1,244 children working and/or living on the streets of Tegucigalpa are described, separating "market" children from "street" children. The latter group is then divided into those who sniff glue and those who do not identify salient distinguishing factors. An OLS regression of drug usage on these variables results in a model that explains 75% of the variance, where family relations, length of time on the street, and delinquency are the most important factors.

Resumen

Se examina la hipótesis que el uso de drogas en niños de la calle en Honduras es una función del aislamiento de las influencias culturales y estructurales en su desarollo social. Se describen datos de 1244 niños que viven o trabajan en las calles de Tegucigalpa, separando "niños del mercado" de "niños de la calle". El ultimo grupo se ha dividido entre los que inhalan pegamento y los que no lo hacen, para identificar factores sobresalientes que los distinguen. La aplicación de una regresión OLS del uso de drogas en estas variables resulta en un modelo que explica el 75 porciento de la varianza, donde los factores mas importantes son: las relaciones famillares, el tiempo pasado en la calle y la delincuencia.

Résumé

On examine l'hypothèse que l'usage de sustances parmi les enfants de la rue au Honduras est en function de l'isolement des influences culturelles et structurelles dans leur development social. On décrit ici les dates de 1244 enfants qui travaille ou habitent dans les rues de Tegucigalpa, en separant les "enfants du marché" des "enfants de la rue". Le dernier group est de plus divisé parmi ceux qui inhalent et ceux qui n'inhalent pas, en ordre d'identifier les facteurs sailleant que les distingue. Une regresion OLS d'usage de sustances sur ces variables resulte dans un model qui explique 75 pourcent de la variance, montrant que les facteurs les plus importants sont: les rélations familiales, le temps passé à la rue et la delincance.

Riassunto

Qui esaminiamo l'ipotesi che l'uso di droga tra i ragazzi di Honduran street sia dipendente all'accrescimento di uno stato di isolamento sociale dalle influenze sia culturali che strutturali. I dati analizzati prendono in considerazione 1244 ragazzi, che lavorano o vivono nelle strade di Tegucigalpa e sono così ripartiti: 1) ragazzi inseriti nel "mercato" del lavoro; 2) ragazzi da strada. Questo secondo gruppo è stato poi suddiviso ulteriormente tra coloro che sniffano droga e coloro che non hanno nessun tratto caratteristico che li distingue. Da una analisi regressiva sull'uso di droga effettuata su queste variabili, in un modello che spiega il 75% della varianza, il rapporto con la famiglia, il tempo trascorso in mezzo alla strada e la delinquenza risultano essere i fattori più importanti.

Drogengebrauch von honduranischen Straßenkindern

Zummenfassung

Wir untersuchen die Hypothese, daß Drogengebrauch unter Straßenkindern in Honduras eine Funktion fortschreitender sozialer Isolation von kulturellen und strukturellen Einflüssen ist. Die Daten von 1244 Kindern, die in den Straßen von Tegucigalpa arbeiten und/oder leben, werden beschrieben, wobei "Marktkinder" von "Straßenkindern" unterschieden werden. Die Straßenkinder werden weiter unterteilt in eine Gruppe, die Klebstoffe (Uhu) schnüffelt, und eine Gruppe, die dies nicht tut, um die wichtigsten Unterscheidungsmerkmale zu identifizieren. Eine lineare Regressionsanalyse des Drogenkonsums mit diesen Variablen führt zu einem Modell, das 75 Prozent der Varianz erklärt, wobei Familienbeziehungen, für die Dauer des Aufenthalts auf der Straße und Delinquenz die wichtigsten Faktoren sind.

Drug- en alcoholgebruik onder straatkinderen in Honduras

Samenvatting

We onderzoeken de hypothese dat druggebruik onder Hondurese straatkinderen vooral wordt bepaald door steeds verdergaande uitsluiting van culturele en structurele invloeden. De dataset bevat 1244 kinderen die werken en/of op straat zwerven in Tegucigalpa. De laatste groep wordt onderverdeeld in degenen die lijm snuiven en in niet-gebruikers om de bepalende factoren voor gebruikers te bepalen. Dit wordt gedaan aan de hand van lineaire regressie, waarbij 75% van de variantie van druggebruik kan worden verklaard. Familiebanden, de lengte van de zwerfperiode op straat en delinquentie zijn daarbij de belangrijkste verklarende factoren.

Наркомания среди бездомных детей в Гондурасе.

Краткое содержание.

В этой статье мы выдвигаем гипотезу о том, что употребление наркотиков среди бездомных детей в Гондурасе является следствием и социальной изоляции. В статье описывается 1244 ребенка, которые работают или живут на улице. Отдельно рассматриваются дети, живущие на рынках. "Уличные" дети подразделяются на тех, кто "нюхает" наркотики и тех, кто не является "явным" наркоманом. Ухудшение ситуации описывается в виде результирующей модели, объясняющей 75% изменений в зависимости от ряда переменных, важнейшими из которых являются отношения в семье, длительность жизни на улице и правонарушения.

洪都拉斯街頭孩童的物質使用

在本文我們驗証洪都拉斯街頭孩童的物質使用是基於與文化和結構性影響隔絶的發展之假設。會描述一千二百個有工作及/或在德告斯加巴街頭居住的孩童，並把「市場」孩童與「街頭」孩童分開。後者會進一步分爲有鼻吸膠水習慣的和沒有此習慣的兩類，以便找出突出的因素。一個把上述變項與藥物服用作普通最少平方迴歸分析的結果顯示，這樣的模型可解釋百分之七十五的方差，而家庭關係、在街頭生活的時間，及違法是最重要因素。

مقدمة

تعاطي المخدرات بين أطفال الشوارع في هندوراس

هنا نحن نختبر فرضية أن تعاطي المخدرات بين أطفال الشوارع في هندوراس هي من تأثير الانعزال التطوري الاجتماعي عن التأثيرات
الثقافية والبنيوية. سوف نصف معلومات عن ١٢٤٤ طفل يعملون أويعيشون في شوارع تيكوجيكالبا (Tegucigalpa) وتفصل هذه المعلومات أطفال الأسواق عن أطفال الشوارع. وأطفال الشوارع يقسمون إلى قسمين, قسم منهم يشمون الصمغ والقسم الآخر لا يشمون الصمغ. تم هذا التقسيم لتسهيل التعرف على العوامل المميزة البارزة لهؤلاء الأطفال. ارتداد (OLS) لتعاطي المخدرات بالاعتماد على هذه المتغيرات ينتج مخطط يفسر ٧٥ بالمائة من الفرق بين أطفال الشوارع الذين يشمون الصمغ وأطفال الشوارع الذين لا يشمون الصمغ حيث أن العلاقات الأسرية والمدة التي مضت على عيشهم في الشوارع والجن وحية عندهم هي العوامل الأكثر أهمية في تفسير هذه الفروقات.

SOUTHEAST ASIANS: ASIAN-PACIFIC AMERICANS AT RISK FOR SUBSTANCE MISUSE

Carolyn Erickson D'Avanzo, D.N.Sc. [*Substance Use Misuse*, 32(7&8), 829–848 (1997)]

Projections indicate that by the year 2000 over a million Cambodians, Laotians, and Vietnamese will be living in the United States. There is sparse information relative to the use of substances by these groups, due to the absence of national prevalence data. The combined stressors that these refugee groups have faced puts them at high risk for substance misuse. Southeast Asians infrequently use substance misuse and mental health services, which has been perceived as a lack of need for services by these groups. In reality, there is a critical shortage of culturally-appropriate treatment and intervention programs as the prevalence of substance misuse increases in these populations.

Resumen

<Projections> indican que para el año 2000, más de un millon de la gente de Cambodia, Laos, y Vietnam vivirán en los EEUU. Existe poca información sobre el uso de drogas en estos grupos. A caso de la aucencia de datos prevalentes. La combinación de estresses que estos grupos han visto les pone a riesgo de maluso de drogas. Asiáticos del sureste raramente usan servicios públicos que tienen que ver con maluso de drogas o salud mental. Esto ha sido visto como falta de necesidad para estos servicios en estos grupos. En realidad existe una falta crítica de programas que son apropriados para culturas especificas y programas de intervención mientras más y más gente malusan drogas en estos grupos.

Résumé

Les projections indiquent qu' en 2000, plus d'un million de Cambodgiens, Laotiens, et Vietnamiens vivront aux Etats-Unis. Cependant il y a peu d'informations sur l'utilisation des substances par ces groupes, à cause de l'absence de données nationales répandues. Les stressors combinés auquels ces groupes de réfuigiés sont soumis, les mettent à fort risque d'usage incorrect des substances. Les Asiatiques du Sud utilisent infréquemment les services d'utilisation correcte des substances et d'aide mentale, et donnent donc l'impression que ces services ne sont pas necéssaires. En realité, il y a un manque critque de traitements et de programmes d'intervention adaptés aux cultures alors que parmi ces populations, l'usage incorrect des substances se répand.

Riassunto

Alcune proiezioni indicano che nell'anno 2000 più di un milione di cambogiani, lao e vietnamiti vivranno negli Stati Uniti. C'è poca informazione relative all'uso di sostanze da parte di questi gruppi, dovuta comunque all'assenza di dati prevalentemente nazionali. Le continue pressioni che questi profughi hanno affrontato, hanno reso quest'ultimi ad alto rischio di abuso di sostanze. Gli asiatici del sud-est, che fanno abuso di sostanze, raramente si servono dei servizi di salute mentale, i quali percepiscono una assenza di bisogno da parte di questi gruppi per tali servizi. In realtà c'è una carenza critica di trattamenti culturalmente appropriati e di programmi di intervento, tale da incrementare prevalentement l'abuso di sostanze tra queste popolazioni.

Das Risiko des Drogenmißbrauchs bei Amerikanern aus dem asiatisch-pazifischen Raum

Zusammenfassung

Prognosen weisen darauf hin, daß im Jahr 2000 mehr als eine Million Kambodschaner, Laoten und Vietnamesen in den Vereinigten Staaten leben werden. Über den Drogengebrauch in diesen Gruppen liegen nur spärliche Informationen vor, was auch durch das Fehlen von landesweiten Daten zum Vorkommen von Drogengebrauch bedingt ist. Die kombinierten Streßfaktoren, denen diese Flüchtlingsgruppen ausgesetzt sind, machen sie zu besonders gefährdeten Risikogruppen für Drogenmißbrauch. Personen aus dem südostasiatischen Raum nutzen aber nur unregelmäßig Beratungs- und Hilfseinrichtungen im Zusammenhang mit Drogenproblemen und psychischen Problemen. Bislang wurde dies als ein nicht vorhandener Bedarf an solchen Einrichtungen gedeutet. Tatsächlich besteht jedoch eine kritische Unterversorgung mit Behandlungs- und Interventionsprogrammen die der jeweiligen Kultur angemessen sind; dabei nimmt das Ausmaß des Drogenkonsums gerade in diesen Bevölkerungsgruppen zu.

Het risico van druggebruik voor Asian-Pacific Amerikanen

Samenvatting

Voorspellingen geven aan dat er in het jaar 2000 meer dan een miljoen Cambodjanen, Laotianen en Vietnamezen in de Verenigde Staten zullen wonen. Vanwege de afwezigheid van data met betrekking tot nationale invloeden is er echter slechts weinig informatie beschikbaar over drug- en alcoholgebruik onder deze bevolkingsgroepen. Dit terwijl ze, vanuit hun achtergrond als vluchteling, meer dan evenredig blootstaan aan de risico's van druggebruik. Zuidoost-Aziaten zijn slechts incidentele gebruikers van drugs en van psychisch-medische voorzieningen, wat geïnterpreteerd wordt als een geringe behoefte van deze groep aan dergelijke voorzieningen. In werkelijkheid is er echter een groot tekort aan cultureel-specifieke behandelingen en interventie-programma's bij een toenemend druggebruik onder deze groepen.

Юго-восточные азиаты - группа риска.

Краткое содержание.

Прогнозы говорят, что к 2000 году более миллиона камбоджийцев, лаосцев и вьетнамцев будут жить в Соединенных Штатах. Нет точных данных о степени распространения наркомании среди этих народов. Однако стрессовые ситуации, с которыми столкнулись люди из этих стран, несомненно, повышают вероятность употребления наркотиков в их среде.

Выходцы из юго-восточной азии редко обращаются в психологические и наркологические службы, что послужило поводом считать, что они не нуждаются в таковых. На самом же деле количество наркоманов среди них непрерывно растет, и необходимо более масштабное вмешательство специалистов в их проблемы.

東南亞人：物質誤用的危險

推計數字顯示至二零零零年時會有超過一百萬東浦寨人、寮國人及越南人在美國居住。但是，由於沒有全國性流行率資料，有關這些群體的物質使用的消息很是缺乏。這些難民群體所面對的一起出現的壓力來源，使他們有物質誤用的高度危險。東南亞人很少使用物質誤用及精神科醫療服務，因而被人以爲他們對這些服務沒有需要。事實上，隨著這些人口的物質誤用流行率的增加，具文化適切性的治療和干預程序是極端缺乏的。

مقدمة

الآسيويين الجنوب شرقيين: معرضون لخطر تعاطي المخدرات

إن التقديرات المستقبلية تبين انه في سنة ٢٠٠٠ سيعيش في الولايات المتحدة اكثر من مليون كمبودي ولاوي وفيتنامي. هنالك معلومات قليلة بالنسبة لتعاطي هؤلاء للمواد التي تسبب الإدمان ولكن ذلك يرجع لغياب المعلومات الشاملة الوطنية (الأهلية). إن الضغوطات المترابطة التي تواجهها هذه المجموعات من اللاجئين تجعلهم معرضين بنسبة كبيرة لخطر تعاطي المخدرات. وان الآسيويين من جنوب شرق آسيا قلما يستخدمون خدمات الصحة النفسية وخدمات علاج الإدمان على المخدرات وقد فهم ذلك بشكل خاطئ كعدم حاجة هؤلاء الأشخاص لهذه الخدمات. ولكن في الواقع هناك نقص حاد في هذه الخدمات التي تناسب ثقافة وحضارة هؤلاء المجموعات التي يتزايد فيها عدد المتعاطين والمدمنين على المخدرات.

ETHNIC DIFFERENCES IN SUBSTANCE USE AND ALCOHOL-USE-RELATED MORTALITY AMONG FIRST GENERATION MIGRANTS TO ENGLAND AND WALES

Larry Harrison, Matthew Sutton, and Eric Gardiner [*Substance Use Misuse*, 32(7&8), 849–876 (1997)]

Epidemiological studies among migrant ethnic groups are potentially important as a way to provide insight into the relative importance of genetic, cultural, and socioeconomic factors in the etiology of substance use disorders. This paper summarizes prior United Kingdom studies of the prevalence of substance-use-associated problems in different ethnic groups before analyzing trends in recent mortality data by country of birth. On this evidence, rates of alcohol-related mortality may be marginally higher for those born in the Caribbean than for the native British, but are substantially raised for those born in Ireland and the Indian subcontinent. There is some indication that rates for the Caribbean and possibly the Irish groups have risen more rapidly than for the national population over a 12-year period. These differences in mortality rates seem to have arisen for complex reasons.

Resumen

Los estudios epidemiológicos sobre los grupos etnicos migratorios son potencialmente importantes para proveer una nueva percepción de la importancia relativa de factores genéticos, culturales y socioeconónicos en la aeteología de las enfermedades relacionadas con el consumo de sustancias. Este artículo recapitula estudios ilevados a cabo en el Reino Unido sobre la prevalencia de problemas por consumo de sustancias en varios grupos étnicos antes de pasar a analizar los recientes datos de mortandad por pais de origen. Con esta evidencia, el indice de muertes relacionadas con el consumo de alcohol puede aparecer marginalmente más alta para aquellos nacidos en el área del Caribe que para los nativos británicos. Sin embargo, este indice se ve substancialmente elevado en los grupos de los nacidos en Irlanda y en el subcontinente Indio. Existen indicios de que el nivel de mortandad para los grupos del Caribe y posiblemente de Irlanda se ha elevado más rápidamente que para el resto de la población nacional en un periodo de doce años. Estas diferencias en los índices do mortandad parecen haber surgido por razones complejas.

Résumé

Les études d'épidémiologie parmi les groupes ethniques migrants sont potentiellement importantes comme moyen de parvenir à comprendre l'importance relative des facteurs génétiques, culturels et socio-économiques dans l'aetiologie des désordres de la dépendance. Cet article résume les études antérieures du Royaume-Uni sur la prévalence des problémes de dépendance chez les différents groupes ethniques avant d'analyser les tendances des données de mortalité récentes par pays d'origine. D'aprés celles-ci, les taux de moralité se rapportant à l'alcool sont légèrement plus élevés pour les gens originaires des Caraïbes que pour les Britanniques, mais nettement plus élevé pour ceux qui sont nés en Irlande et sur le continent indien. Il semblerait que les taux pour les Caraïbes et peut-être l'Irlande aient augmenté plus rapidement que pour la population nationale sur une période de douze ans. Ces différences dans les taux de mortalité semblent avoir augmenté pour des raisons complexes.

Riassunto

Malgrado gli stereotipi persistenti intorno alle persone "nere" sull'uso che fanno di alcool e droga, si conosce poco l'influenza che le differenti etnie esercitano nell'analisi di problemi relativi all'assunzione di sostanze psicoattive in Inghilterra e nel Galles. La maggior parte di dati attendibili che si hanno a disposizione riguardano i dati relativi alla mortalità da alcool e sono limitati alla prima generazione di emigranti identificati dal paese di provenienza e che non sono documentati tra i certificati di morte Britannici. Questo documento riassume in prevalenza studi che indagano sulla natura dei problemi in differenti gruppi etnici prima di analizzare it dati di recente mortalità secondo il paese di nascita. In questo modo, i dati relativi alla mortalità dovuta ad abuso di sostanze alcoliche può essere marginalmente più alto per coloro che sono nati ai Caraibi rispetto a coloro che sono nati in Gran Bretagna, ma sono sostanzialmente elevati per quelli nati in Irlanda e nel Sub continente Indiano. Ci sono alcuni elementi relativi alla mortalità da alcool che indicano che, per gruppi Irlandesi e Caraibici, la mortalità rispetto alla popolazione nazionale sia aumentata negli ultimi 12 anni, e che questo aumento sia incrementato con l'aumento della popolazione nazionale.

Ethnische Unterschiede im Rauschmittelgebrauch und in der mit Alkohol verbundener Sterblichkeit unter Einwanderern der ersten Generation nach England und Wales

Zusammemfassung

Epidemiologische Studien in ethnischen Migrantengruppen können einen wichtigen Beitrag zur Aufdeckung der jeweiligen Bedeutung genetischer, kultureller und sozio-ökonomischer Faktoren bei der Entstehung von Rauschmittelabhängigkeiten leisten. Dieses Papier faßt vorliegende britische Studien zum Ausmaß von Drogenproblemen in unterschiedlichen ethnischen Gruppen zusammen, und untersucht Trends in aktuellen Daten zur Sterblichkeit nach dem jeweiligen Geburtsland. Die Ergebnisse deuten darauf hin, daß die Sterblichkeitsraten im Zusammenhang mit Alkoholmißbrauch bei in der Karibik Geborenen geringfügig höher sind als die einheimischen Briten. Die Sterblichkeitsraten der in Irland und auf dem indischen Subkontinent Geborenen liegen jedoch deutlich höher. Einige Anzeichen sprechen dafür, daß die Sterblichkeitsraten für die karibischen und möglicherweise die irischen Gruppen während einer Periode von zwölf Jahren stärker gestiegen sind als im nationalen Bevölkerungsdurchschnitt. Sehr komplexe Gründe scheinen für diese Unterschiede in den Sterblichkeitsraten verantwortlich zu sein.

Etnische verschillen in druggebruik en overlijden wegens alcoholgebruik onder eerste-generatie immigranten naar Engeland en Wales

Samenvatting

Epidemiologisch onderzoek onder etnische immigranten vormt een belangrijk middel om inzicht te verkrijgen in de relatieve belangrijkheid van genetische, culturele en sociaal-economische factoren in de etiologie van drug- en alcoholmisbruik. Deze studie geeft eerst een overzicht van eerdere studies in Groot-Brittanië naar de rol van druggebruik in diverse etnische groepen, waarna de trends in mortaliteit naar geboorteland worden geanalyseerd. Hieruit blijkt dat alcohol-gerelateerde mortaliteit voor emigranten uit het Caribisch gebied iets hoger is dan voor de allochtone Britten, maar dat deze substantieel hoger is voor degenen die geboren zijn in Ierland of het Indische subcontinent. Ook zijn er aanwijzingen dat de mortaliteitspercentages voor Caribeanen en -wellicht- ook de Ieren de laatste 12 jaren sterker zijn gestegen dan voor de Britse populatie. De redenen voor deze verschillen in mortaliteitspercentages blijken echter complex.

Относительная смертность среди первого поколения переселенцев в Англию и Уэльс.

Краткое содержание.

Несмотря на устойчивый стереотип по вопросу наркомании среди чернокожего населения, мы имеем недостаточно информации об употреблении наркотиков среди различных этнических групп Англии и Уэльса. Данные учитывают смертность в связи с употреблением алкоголя и описывают первое поколение переселенцев по признаку года и места рождения (национальность в английских свидетельствах о смерти не пишется).
Работа суммирует данные прежних исследований, проводившихся в Объединенном Королевстве на тему распространения наркотиков среди различных этнических групп, а затем анализирует данные о смертности в зависимости от страны исхода.
Согласно этим данным, смертность от алкоголизма незначительно выше у выходцев из района Карибского моря, по сравнению с британцами, но значительно выше у уроженцев Ирландии и Индии. Имеются данные, что смертность выходцев из района Карибского моря и из Ирландии от алкоголизма возросла за последние 12 лет гораздо быстрее, чем смертность местного населения. Уровень смертности среди уроженцев полуострова Индостан вырос, по-видимому, в той же степени, что и среди местных жителей.

移民至英格蘭和威爾斯的第一代移民的與酒精有關的死亡率

雖然對於黑人的酒精和藥物服用的固定朔型有很多，但關於英格蘭和威爾斯不同族群在精神科物質使用引起的問題卻很少爲人所知。最可靠的資料是與酒精有關的死亡率，而這些資料只局限於由出生地點來判斷的第一代移民，因爲英國的死亡証明書裡並無所屬族群的記錄。本文撮要敘述過去英國不同族群的物質誤用問題的流行率研究，然後分析近期不同出生地點的死亡率資料。基於此証據，在加勒比海出生的人比在英國本土出生的人有少許較高的與酒精相關的死亡率，但此死亡率在愛爾蘭出生的人和在印度

半島出生的人當中卻顯著提升。有些跡象顯示，加勒比海社群的與酒精相關的死亡率，及有可能愛爾蘭社群的與酒精相關的死亡率也一樣，在過去十二年來的升幅比全國人口的與酒精相關的死亡率的升幅爲高。在印度半島出生的人的與酒精相關的高死亡率的升幅，似乎與全國人口的與酒精相關死亡率的升幅同步。

مقدمة

الفوارق العرقية في تعاطي المخدرات والكحول ونسبة الوفاة المتعلقة بذلك بين الجيل الأول من المهاجرين في إنجلترا وويلز

بالرغم من التنميط المستمر حول الشعب الأسود وتعاطيه الكحول والمخدرات فان هناك القليل من المعرفة حول التنوعات العرقية ونسبة المشاكل المتعلقة بتعاطي المخدرات التي تنعكس من دافع نفسي في إنجلترا وويلز. المعلومات الأكثر وثوقا هي التي تتعلق بنسبة الوفاة التي سببها شرب الكحول وهذه المعلومات تضم الجيل الأول فقط من المهاجرين نسبة إلى الدول التي ولدوا فيها لان العرق لا يكون مسجلا في شهادات الوفاة البريطانية. هذا البحث يلخص دراسات بريطانية مسبقة عن ظهور مشاكل المخدرات بين المجموعات العرقية المختلفة قبل تحليل المعلومات المتعلقة بنسبة الوفاة الحديثة المنسوبة إلى مكان الولادة. بناء على هذه المدلولات فان نسبة الوفاة بسبب شرب الكحول يمكن أن تكون أعلى بقليل عند المولودين في الكاريبي من تلك النسبة عند الإنجليزي الأصل ولكن نسبة الوفاة لنفس السبب أعلى بشكل ملحوظ للمولودين في ايرلندا وشبه القارة الهندية. هناك ما يوحي أن نسبة الوفاة بسبب شرب الكحول للمجموعات الكاريبية وبالإمكان الايرلندية قد ارتفعت بمعدل اكبر من المجموعات المحلية في الاثنا عشر سنة الأخيرة والنسبة العالية للوفاة عند المولودين في شبه القارة الهندية تظهر أنها ارتفعت بشكل يوازي ارتفاع نسبة الوفاة عند المجموعات المحلية.

SUBSTANCE USE PATTERNS AMONG HOMELESS MIGRANTS AND NONMIGRANTS IN CHICAGO

Jonathan B. VanGeest, M.A., and Timothy P. Johnson, Ph.D. [*Substance Use Misuse*, 32(7&8), 877–907 (1997)]

This paper uses data abstracted from 465 client records randomly selected from the current files of a downtown medical clinic in Chicago, Illinois to examine substance use among 85 immigrant and 380 nonimmigrant homeless and "at-risk" homeless adults. Immigrants to the United States reported lower levels of current cigarette, alcohol, and drug use compared to nonimmigrants in the sample. Immigrants were also less likely to report potential substance user treatment needs. Immigrants, however, did not differ from nonimmigrants in the reported quantity or frequency of cigarette and alcohol use. Drug use among homeless immigrants was also higher than estimates of misuse in the general population. The literally homeless in the sample reported higher levels of substance use compared to "at-risk" homeless. The literally homeless were also more likely to report higher levels of consumption and were more likely to have potential substance user treatment needs. The role of stress in the etiology of substance misuse among homeless immigrants and nonimmigrants is discussed. Implications for the treatment of these diverse populations are also addressed.

Resumen

Este papel usa información abstaído de 465 archivos de clientes por una selección hecha al azar de los archivos actuales de una clínica médica en el centro de Chicago, Illinois para examinar el uso de substancia entre 85 immigrante y 380 no immigrante adultos sin hogar o adultos en riesgo de estar sin hogar. Immigrantes as los Estados Unidos reportaron niveles mas bajos de uso actual de cigarrillos, alcohol, y drogas comparado a no immigrantes en la muestra. Ademas, immigrantes fueron menos probable para reportar la potencial de necesidad de tratamiento para el uso de substancias. Sin embargo, no huvo diferencia entre los immigrantes y no immigrantes en la cantidad o frecuencia reportada de uso de cigarrillo y alcohol. Uso de drogas entre los immigrantes sin hogar también fue mas alto que el estimado de mal empleo en la población general. Los que en realidad estan sin hogar en la muestra reportaron riveles mas altos de use de substancias comparado a los que estan en riesgo de estar sin hogar. Ademas, los que en realidad estan sin hogar fueron

mas probables de reportar nivels mas altos de consumísión y mas probable de tener la potencial de necesidad de tratamiento para el uso de substancias. También se discute el papel de mortificación en la etiologia de mal empleo de substancia entre los immigrantes y no immigrantes sin hogar. Las implicaciónes para el tratamiento de esta población diverso también se discuten.

Résumé

Ce papier se base sur les données extraites de 465 dossiers de clients choisis au hasard des dossiers courants d'un centre médico-social en le centre de Chicago, Illinois pour examiner l'usage de la drogue parmi les adultes sans-abri et ceux qui risquen d'être sans-abri. De ces 465 clients figurent 85 immigrés et 380 non-immigrés. Les immigrés aux États-Unis ont rapporté à un moindre dregé l'usage actuel des cigarettes, de l'alcool, et de la drogue en comparaison des non-immigrés qui faisaient partie de cet échantillon. Il était aussi moins commun pour les immigrés de rapporter un potentiel besoin de traitement. Cependant, il n'y avait pas de différence de la quantité ou de la fréquence de l'usage des cigarettes et de l'alcool par des immigrés et les non-immigrés. L'usage de la drogue parmi les immigrés sans-abri était aussi plus élévé que l'abus estimé dans la population en général. Les vrais sans-abri dans l'échantillon ont rapporté l'usage de la drogue à un plus haut niveau que ceux qui risquent d'être sans-abri ont rapporté. Les vrais sans-abri ont aussi rapporté avec plus de fréquence un plus haut niveau de consummation et ils avaient plus tendence à avoir besoin de traitement pour l'abus de la drogue. Le rôle de stress dans l'étiologie de l'abus de la drogue parmi les immigrés et les immigré sans-abri est discuté. Le papier s'addresse aussi aux implications pour le traitement de ces populations diverses.

Riassunto

Questo studio utilizza dati estratti da 465 record randomicamente selezionati da file attuali di una clinica medica al centro di Chicago nell'Illinois, per esaminare l'uso di sostanze tra 85 immigrati e 380 non immigrati, entrambi senza case, e il rischio che essi diventino adulti "senza casa". L'uso di sigarette, alcool e droga, risulta essere inferiore nel campione degli immigrati verso gli Stati Uniti rispetto al campione dei non immigrati. Tra gli immigrati che risultano essere potenziali abusatori di sostanze, alcuni hanno bisogno di un trattamento. Gli immigrati, tuttavia, non presantano differenze dai non immigrati nella quantità e nella frequenza rispetto all'uso di sigarette e alcool. L'uso di droga tra i "senza tetto" immigrati risulta essere anche più alta delle stime relative all'abuso tra la popolazione generale. I "senza tetto" nel cam-

pione, hanno riportato livelli più alti nell'uso di sostanze rispetto al rischio di diventare dei "senza tetto". I "senza tetto" hanno anche riportato livelli più alti nel consumo di droghe e di aver quindi bisogno di trattamenti. Viene discusso il ruolo dello stress da abuso di sostanze, da un punto di vista epidemiologico, tra i "senza tetto" immigranti e non immigranti. Inoltre, viene discusso sulla necessità di utilizzare trattamenti differenziati che tengano conto di queste diverse popolazioni.

Drogengebrauchsmuster bei obdachlosen Einwanderern und nicht obdachlosen Einwanderern in Chicago

Zusammenfassung

Dieses Papier verwendet Daten aus 465 Patientenakten, die zufällig aus den aktuellen Beständen einer innerstädtischen Klinik in Chicago ausgewählt wurden, um die Verwendung von Drogen unter 85 eingewanderten und 380 nicht eingewanderten Obdachlosen und von Obdachlosigkeit bedrohten Erwachsen zu untersuchen. Die Einwanderer in die Vereinigten Staaten berichten eine geringeres Ausmaß an aktuellem Genuß bzw. Gebrauch von Zigaretten, Alkohol und Drogen als die Nichteinwanderer in der Stichprobe. Einwanderer berichteten auch weniger häufig einen potentiellen Behandlungsbedarf in Zusammenhang mit Drogengebrauch. Die Einwanderer unterschieden sich jedoch nicht von den Nichteinwanderern hinsichtlich der berichteten Menge oder Häufigkeit des Zigaretten- und Alkoholkonsums. Ein Vergleich mit vorliegenden Schätzwerten zeigt bei obdachlosen Einwanderern einen höheren Drogenkonsum als im Bevölkerungsdurchschnitt. Die tatsächlich Obdachlosen im Sample berichteten ein höheres Ausmaß der Drogenverwendung als die von Obdachlosigkeit Bedrohten. Die tatsächlich Obdachlosen berichteten auch häufiger ein höheres Konsumniveau und hatten häufiger einen potentiellen Behandlungsbedarf in Zusammenhang mit Drogengebrauch. Die Rolle die Streß bei der Entstehung des Drogenmißbrauchs bei obdachlosen Einwanderern und Nichteinwanderern spielt wird diskutiert. Implikationen für die Behandlung dieser unterschiedlichen Populationen werden angesprochen.

Drug- en alcoholpatronen onder thuisloze emigranten en niet-migranten in Chicago

Samenvatting

Aan de hand van een aselecte steekproef van 465 patiëntgegevens van een 'downtown' medische kliniek in Chicago, Illinois wordt het drug- en alcoholgebruik onderzocht van 85 immigranten en 380 niet-migranten die dakloos zijn, of tot de risicogroep om dakloos te worden behoren. De immigranten uit de steekproef geven aan minder sigaretten, alcohol en drugs te gebruiken dan de niet-migranten. Immigranten scoren ook lager op de behoefte aan behandeling voor (potentieel) drug- en alcoholgebruik. Het feitelijke gebruik van sigaretten en alcohol verschilt echter niet tussen deze twee groepen. Druggebruik onder dakloze immigranten bleek eveneens relatief hoger te zijn dan schattingen van druggebruik onder de rest van de populatie. De feitelijke thuislozen uit de steekproef tonen een hoger druggebruik dan degenen in de risicogroep (om dakloos te worden). Deze eerste groep kent ook een hoger gebruik en een grotere behoefte aan behandeling voor drug- en alcoholgebruikers. Ook komt het belang van stress in de etiologie van druggebruik onder dakloze immigranten aan bod en worden de implicaties voor behandeling van de verschillende bevolkingsgroepen besproken.

Наркомания среди бездомных иммигрантов по сравнению с местным населением в Чикаго.

Краткое содержание.

Настоящая статья основана на случайно выбранных данных медицинской клиники в Чикаго, штат Иллинойз. 85 иммигрантов и 380 неиммигрантов, бездомных или на грани потери жилья, исследовались с точки зрения употребления наркотиков. Согласно этим данным, иммигранты меньше курят, пьют и употребляют наркотики, чем коренные жители США. В наркологические диспансеры иммигранты обращаются реже. Однако на деле частота употребления спиртных и табачных изделий среди иммигрантов не отличается от местных жителей, а уровень употребления наркотиков среди них даже выше. Бездомные употребляют больше наркотиков, чем потенциально бездомные (так называемая "группа риска"). Также бездомные чаще заболевают туберкулезом легких и являются потенциальными пациентами соответствующих медицинских служб.
Работа объясняет роль стресса в этиологии иммигрантов и местных жителей. В статье также обсуждается вероятность обращения в медицинсткие службы различных групп населения.

芝加哥無家可歸的移居者與非移居者的物質使用模式

本文的資料來自從伊利諾州芝加哥城一間市中心的醫務診所的近期檔案中隨機抽出的四百八十個顧客個案的物質使用，當中包括八十五個移民的及三百八十個非移民的無家可歸及有無家可歸危險的成年人。在這樣本中，來美國的移民比非移民陳述較低近期香煙，酒精和藥物服用的程度。移民亦較不會陳述潛在物質使用者的治療需要。然而，移民與非移民在陳述的香煙和酒精使用的數量與頻率方面卻沒有分別。無家可歸的移民的藥物服用程度亦高於估計的全部人口的誤用。在樣本裡，眞正無家可歸的人比有無家可歸危險的人陳述較高的物質使用水平。眞正無家可歸的人亦陳述較高水平的潛在物質使用者治療服務及需要。壓力在無家可歸的移民及非移民物質誤用的病原裡所扮演的角色將會被討論。也會探討對這些不同人口的治療的啓示。

مقدمة

تعاطي المخدرات بين المهاجرين المتشردين والمحليين المتشردين في شيكاغو

إن هذا البحث يعتمد على معلومات مأخوذة من سجلات ٤٦٥ مريض اختيرت عشوائيا من الملفات الحديثة في عيادة طبية في وسط مدينة شيكاغو. الينويز لكي ندرس مشكلة تعاطي المخدرات بين ٨٥ مهاجر و٣٨٠ محلي متشرد أومعرض للتشرد وكلهم بالغين. المهاجرين إلى الولايات المتحدة سجلوا مستوى اقل من التدخين وشرب الكحول وتعاطي المخدرات بالمقارنة مع المحليين في هذه العينة. وتبين أيضا إن المهاجرين لديهم احتمالية اقل لإعطاء نتائج في الدراسة عن الحاجات العلاجية لمتعاطي المخدرات الاحتماليين. ولكن لم يختلف المهاجرين عن المحليين في كمية وتردد التدخين وشرب الكحول. أما نسبة تعاطي المخدرات بين المهاجرين المتشردين كانت أعلى من تقديرات التعاطي بين السكان بشكل عام. المتشردين في العينة بينوا نسبة اكبر من تعاطي المخدرات بالمقارنة مع المعرضين للتشرد. وكان المتشردين أيضا اكثر احتمالية لتسجيل مستوى أعلى من الاستهلاك أوالتعاطي واحتمالية أكبر أيضا لتسجيل الحاجات العلاجية لمتعاطي المخدرات الاحتماليين. سوف نناقش أيضا دور الضغط النفسي في تحديد أسباب تعاطي المخدرات بين المهاجرين المتشردين والمحليين المتشردين. وسوف نخاطب أيضا إمكانية استخدام العلاج لهذه المجموعة المختلفة من السكان.

DRUG PROBLEMS AMONG IMMIGRANTS AND REFUGEES IN THE NETHERLANDS AND THE DUTCH HEALTH CARE AND TREATMENT SYSTEM

Govert F. van de Wijngaart (*Substance Use Misuse*, 32(7&8), 909–938 (1997)]

Immigration from former colonies and the influx of refugees whose disadvantaged situation in society often leads to drug problems is described. The Dutch Government provides for a wide variety of services for drug users which include programs for minorities like the Surinamese, Moluccan, Moroccan, and Turkish communities. However, they are either executed poorly or are based too much on "White" methods. An account of a survey about the current situ-

ation of black Surinamese women in the Netherlands is given, and the situation of refugees in the Netherlands as it relates to drug use is described.

Resumen

Govert F. van de Wijngaart describe la immigración de las antiguas colonias y la afluencia de refugiados y obreros extranjeros cuya situación desfavorable en la sociedad lleva muchas veces a problemas de droga. El gobierno holandés mantiene una gran variedad de servicios para consumidores de drogas en la cual están incluido programas para minorías como las surinamesa, moluca, maroqui y turca. Sin embargo, estos programas han sido realizado deficientemente o están basado en exceso en métodos 'blancos'cos. Se da un informe sobre la situación actual de las mujeres negras surinamesas en los Paises Bajos y se describe la situación de los refugiados en Holanda relacionada con el consumo de drogas.

Résumé

Govert F. van de Wijngaart décrit l'immigration des pays de l'ancien empire colonial hollandais e l'influx récent des travailleurs immigrés et des réfugiés dont la situation défavorisée amène souvent aux problèmes de drogues. Le gouvernement hollandais arrange équipements differentiées pour des toxicomanes y compris des programmes concentrées sur minorités divers comme lesquelles de Surinamiens, Moluquois, Marocains et de Turcs. Cependant ils sont realisés faiblement out bien souffrent des méthodes ethnocentriques. Une recherche à la situation actuelle des Surinamiennes créoles est exposée ainsi que la situation des refugiés en ce qui concerne la consommation des drogues.

Riassunto

L'immigrazione e l'affluenza dei profughi dalle colonie di un tempo, ha portato a problemi legati all'uso di dorga coloro che si sono trovati in una situazione di svantaggio nella società. Il Governo Olandese provvede un ampia gamma di servizi per coloro che usano droga. Questi servizi includono programmi per minoranze come le communità dei surinamesi, dei moluccani, dei marocchini e dei turchi. Questi programmi, comunque, sono eseguiti male o basati troppo su metodi "bianchi". Il rapporto fornisce una panoramica sulla situazione attuale delle donne surinamesi nere nei Paesi Bassi, e descrive la situazione dei profughi nei Paesi Bassi che hanno a che fare con l'uso di droga.

Drogenprobleme bei Einwanderern und Flüchtlingen in den Niederlanden und das holländische Gesundheitssystem

Zusammenfassung

Govert F. van de Wijngaart beschreibt die Einwanderung aus den früheren niederländischen Kolonien und den Zustrom von Flüchtlingen, deren Benachteiligung in der Gesellschaft oft zu Drogenproblemen führt. Die niederländische Regierung stellt eine breite Palette von Hilfsangeboten für Drogenkonsumenten bereit, die u.a. auch Programme für Minderheiten wie Surinamesen, Molukker, Marrokaner und Türken umfassen. Diese Programme werden jedoch entweder schlecht durchgeführt oder sie sind zu sehr an "weißen" Methoden orientiert. Es wird über einen Survey zur gegenwärtigen Situation schwarzer surinamesischer Frauen in den Niederlanden berichtet. Die Situation von Flüchtlingen im Zusammenhang mit Drogenkonsum in den Niederlanden wird beschrieben.

Drugproblemen onder immigranten en vluchtelingen in Nederland en het Nederlandse gezondheids-systeem

Samenvatting

Govert F van de Wijngaart beschrijft de immigratie vanuit de vroegere koloniën en de toestroom van vluchtelingen voor wie de achtergestelde situatie in de samenleving vaak aanleiding is tot drug- en alcoholmisbruik. De Nederlandse overheid kent vele hulpprogramma's voor druggebruikers, inclusief specifieke programma's voor minderheden zoals Surinamers, Molukkers, Marokkanen en Turken. Deze specifieke programma's worden echter slecht uitgevoerd of zijn teveel gebaseerd op 'blanke' methoden. Er wordt ingegaan op de huidige situatie met betrekking tot druggebruik onder Surinaamse vrouwen en onder vluchtelingen in Nederland.

Проблема наркомании среди иммигрантов и беженцев в Нидерландах и голландская система здравоохранения.

Краткое содержание.

Дискриминированное положение иммигрантов из бывших колоний и беженцев приводит к распространению наркомании в их среде. Голландское правительство предоставляет разнообразные услуги по помощи наркоманам, в частности имеются специальные программы для национальных меньшинств, например суринамцев, молюккан, марокканцев и турок. Однако выполнение таких программ затруднено по ряду причин. Настоящая статья описывает положение женщин суринамского происхождения в Голландии, а также положение беженцев с точки зрения наркомании.

荷蘭的移民和難民的藥物問題與
荷蘭的健康照顧及治療系統

從以前殖民地移民而來的人及難民在社會的不利地位往往導致與藥物使用有關的問題。荷蘭政府爲藥用者提供多種類型服務，包括爲蘇利南、摩鹿加、摩洛哥和土耳其等少數族群社區已設的服務。但是，這些服務如非推行不善，便是太倚賴「白人」的方法。本文會描述一個關於在荷蘭的蘇利南黑人婦女和難民有關藥物使用近況的調查。

مقدمة

مشكلة تعاطي المخدرات بين المهاجرين واللاجئين في هولندا وفي
النظام الصحي الهولندي ونظام العلاج

إن الهجرة من مستعمرات سابقة وتدفق اللاجئين ووضعهم السيئ في المجتمع، في كثير من الأحيان يؤدي إلى مشاكل تعاطي المخدرات. إن الحكومة الهولندية توفر الكثير من الخدمات لمتعاطي المخدرات والتي تضم برامج الأقليات مثل مجتمعات السوريناميين والمولكانيين والمغاربة والأتراك. ولكن طريقة تنفيذ هذه البرامج إما تكون منفذة بطريقة سيئة أومعتمدة على أساليب تستخدم 'للبيض.' وسوف تعطى نتائج دراسة عن تعاطي المخدرات الحالي بين النساء السوريناميات السود في هولندا وستعطي كذلك وصف عن وضع اللاجئين بالنسبة لتعاطي المخدرات في هولندا.

HOMELESSNESS AND VULNERABILITY AMONG ADULTS WITH AND WITHOUT ALCOHOL PROBLEMS

Michael R. Sosin, M.A., M.S.W., Ph.D., and Maria Bruni, B.S., A.M. [*Substance Use Misuse*, 32(7&8), 939–968 (1997)]

While many works compare traits of homeless adults across levels of alcohol use, few specifically consider whether drinking status affects determinants of either homelessness or "vulnerability" to homelessness. This paper relies on a 1986 Chicago, Illinois sample (n = 535) to consider the potential contribu-

tions of resources, social network characteristics, disaffiliation, and mental health problems. Results suggest that resource problems may determine homelessness regardless of drinking status. But drinking-associated problems may raise the resource threshold for "vulnerability," reduce the protection afforded by social networks against both homelessness and "vulnerability," increase the deleterious impact of disaffiliation, and spur complicating mental health problems.

Resumen

Mientras muchos estudios comparan las características de adultos que estan sin hogar con los niveles del uso de alcohol, pocos consideran si el nivel de beber influye los determinantes de la falta de vivenda o la vulnerabilidad de estar sin hogar. Este estudio utiliza un muestreo de Chicago, Illinois de 1986 (n=535) para analizar los factores contribuyentes a la falta de vivienda como la falta de recursos, las características de las redes sociales, desconexión social, y problemas de salud mental. Los resultados sugieren que la falta de recursos puede ser que determine la falta de vivienda a pesar del nivel de beber. Sin embargo, los problemas de beber pueden ser que aumenten la vulnerabilidad de la falta de vivienda, reduzcan la protección que ofrecen las redes sociales contra la falta de vivienda y la vulnerabilidad, aumenten los efectos dañosos de la desconexió social, y inciten problemas de salud mental.

Résumé

Beaucoup d'études ont été faites entre la correlation avec les sans abri et l'aloolisme, mais peu d'articles considerent l'état déterminant si l'alcool est un facteur pour les sans-abri ou ceux qui y sont vulnerables. Cet article se rapporte à un échantillon pris à 1986 Chicago, Il. (n = 535) pour considerer les possibilités des resources monetaires, support social, manque d'affiliation et problemes mentaux. La résultat suggére que les problemes monetaires peuvent déterminer le manque d'abri indifféremment de l'état de l'alcoolisme. Mais l'addiction à la boisson peut exacerber les difficultés de moyen d'existence, le support social peut être reduit et le manque d'affiliation complique les problemes mentaux.

Riassunto

Mentre molte trattati paragonano le caratteristiche degli adulti senza tetto attraverso i livelli di uso di alcool, alcuni considerano specificatamente determinate

sia l'influenze dello stato di ubriachezza dei senza tetto che la loro vulnerabilità. Questo articolo fa affidamento su un campione (n = 535) di Chicago, Illinois, del 1986, per considerare i potenziali contributi dei rimedi, delle caratteristiche della rete sociale, della disassociazione dei problemi di salute mentale. I risultati suggeriscono che i problemi di rimedio potrebbero essere la causa della non curanza dei senza tetto del loro stato di ubriachezza. Ma i problemi di alcool possono elevare la soglia di rimedio per la vulnerabilità, ridurre la protezione offerta dalle reti sociali sia contro l'essere senza tetto che contro la vulnerabilità, aumentare l'impatto deleterio della disassociazione e complicare ulteriomente i problemi di salute mentale.

Obdachlosigkeit und das Risiko der Obdachlosigkeit bei Erwachsenen mit und ohne Alkoholproblemen

Zusammenfassung

Viele Studien vergleichen die Eigenschaften von erwachsenen Obdachlosen nach unterschiedlichen Ausprägungen deren Alkoholkonsums. Nur wenige Studien untersuchen, ob das Trinkverhalten die Determinanten von Obdachlosigkeit oder des Risikos der Obdachlosigkeit beeinflußt. In diesem Papier werden an einer Stichprobe aus dem Jahr 1986 (n=535) in Chicago, die potentiellen Einflüsse der vier Determinanten: Ressourcen, Merkmale sozialer Netzwerke, soziale Marginalisierung, und psychische Probleme auf Obdachlosigkeit und Risiko der Obdachlosigkeit untersucht. Die Ergebnisse deuten daraufhin, daß Ressourcenprobleme auch unabhängig vom Trinkverhalten zu Obdachlosigkeit führen können. Das Risiko der Obdachlosigkeit kann jedoch durch Alkoholprobleme bereits auf einem höheren Ressourcenniveau entstehen; Alkoholprobleme können den von sozialen Netzwerken gegebenen Schutz vor Obdachlosigkeit und dem Risiko der Obdachlosigkeit reduzieren; die negative Auswirkung von sozialer Marginalisierung verstärken und die Entstehung von erschwerenden psychischen Problemen begünstigen.

Daklozen en -kwetsbaarheid onder volwassenen met en zonder alcoholproblemen

Samenvatting

Terwijl veel onderzoek zich richt op het gedrag van daklozen voor verschillende gradaties van alcoholgebruik, wordt er slechts weinig onderzoek uitgevoerd naar de relatie tussen drankgebruik en de (verhoogde) kans om dakloos te worden. Dit onderzoek gaat uit van een steekproef (n=535) uit Chicago, Illinois en gaat na wat de mogelijke effecten zijn van financiële middelen, sociale netwerken, verbreken van (familie)banden en geestelijke problemen. De uitkomsten suggereren dat geldproblemen - onafhankelijk van het alcoholgebruik- aanleiding kunnen zijn om dakloos te worden. Drankproblemen kunnen echter de kwetsbaarheid om dakloos te worden verhogen, alsmede de bescherming van sociale netwerken verminderen, de kans op verbreken van familiebanden verhogen en complicerende geestelijke gezondheidsproblemen bespoedigen.

Бездомность и социальная уязвимость среди взрослых, страдающих алкоголизмом, по сравнению с остальными.

Краткое содержание.

Существует целый ряд работ, описывающих различные степени алкоголизма среди бездомных. При этом сама зависимость числа бездомных или потенциально бездомных от употребления спиртных напитков исследуется сравнительно редко. Настоящая статья описывает исследование по выявлению материальных, социальных и душевных проблем, связанных с употреблением алкоголя, которое было проведено в Чикаго в 1986 году.
Употребление спиртных напитков увеличивает расходы, повышает вероятность выпадения из социальной группы и различных душевных расстройств.

有酒精問題和無酒精問題的成年人的無家可歸及容易受害性

雖然很多研究都就不同酒精使用程度比較無家可歸成年人的特徵，但很少研究考慮飲酒狀況是否會影響無家可歸或無家可歸容易受害性的因素。本文透過一個一九八六年於依利諾州芝加哥市的有五百三十五人的樣本，來探討資源、社會網絡特徵、缺乏與人建立關係，及精神健康問題的潛在貢獻。結果顯示無論飲酒狀況如何，資源性問題可能導致無家可歸。但是，酒精問題可能增加容易受害性的資源、減低社會網絡對無家可歸及容易受害性的保護、增加缺乏與人建立關係所帶來的壞影響，及使精神健康問題變得更複雜。

مقدمة

التشرد وقابلية التعرض بين الناضجين مع أو بدون مشاكل الكحول

بالرغم من أن هناك الكثير من الدراسات التي تقارن صفات المتشردين الناضجين باعتبار درجات تعاطي الكحول إلا أن القليل منها فقط يأخذ بعين الاعتبار ما إذا كانت درجة الشرب تؤثر على ما يحدد التشرد أو مدى القابلية للتشرد. إن هذا

البحث يعتمد على عينة عددها ٥٣٥ شخص أخذت من شيكاغو، الينويز سنة ١٩٨٦. وتعتمد هذه الدراسة على دراسة احتمالات تأثير الموارد الشخصية وصفات الشبكة الاجتماعية وعدم الاندماج أو الانتماء ومشاكل الصحة النفسية. تبين النتائج أن الصعوبات في الحصول على الموارد وعدم توفرها قد يؤدي إلى التشرد بدون النظر إلى درجة تعاطي الكحول. ولكن من ناحية أخرى مشكلة تعاطي الكحول قد ترفع سهولة فقدان الموارد وتنقص من الحماية التي تمنحها العلاقات الاجتماعية ضد التشرد وأيضا ضد القابلية للتشرد. وتعاطي الكحول أيضا قد يزيد من تأثير عدم الانتماء الضار ويؤدي لتعقيد المشاكل النفسية للفرد الناضج.

"SUBSTANCE ABUSE" DISORDERS AMONG RUNAWAY AND HOMELESS YOUTH

Michele D. Kipke, Ph.D., Susanne B. Montgomery, Ph.D., Thomas R. Simon, Ph.Dc., and Ellen F. Iverson, M.P.H. [*Substance Use Misuse*, 32(7&8), 969–986 (1997)]

This study used systematic sampling methods to recruit a sample of 432 homeless youth from both service and natural "hang-out" sampling sites. According to DSM-III criteria, the majority of respondents were classified as having an alcohol and/or illicit "drug abuse" disorder (71%). The results from multivariate logistic regression analyses indicate that cumulative length of time homeless is positively associated with risk for an "abuse" disorder. The implications of these findings are recommendations for service interventions are discussed.

Resumen

Este estudio utiliza un método systemático que recluta uuna muestra de 432 jovenes sin hogar, entre los que se incluyen los que utilizan los servicios para jovenes como los que se congregan en diferentes lugares por las calles. Según el criterio del DSM-III, la mayoría de los entrevistados fueron clasificados como abusadores de alcohol y/o drogas (71%). Los resultados de los análises de regresión logística multivariada indican que hay una asociación positiva entre el tiempo que la persona esta sin hogar y el riesgo de caer en el abuso de

alcohol y/o drogas. Las implicaciones de estos resultados y recomendaciones para las intervenciones son discutidas.

Résumé

Cette étude a utilisé une methode sytématique peur recruter prés de 432 jenues sans domiciles. Ces jenues viennent de differents services ou de different endroits oú ils sé recontrent. D'après nos critéeres de DSM-III la majorité des candidats abusaient sòit l'alcohol ou les substances illegales (71%). Les resultats obetnu des differentes analyses nous demontrant que le plus longtemps les candidats etaint sand domiciles, la plus grande chance de risque d'abuse. L'implication de les resultats et les recommendations pour un service d'interventions cette recommende.

Riassunto

Questo studio ha usato metodi di campionamento sistematici per la costruzione di un campione di 432 giovani "senza tetto", provenienti in parte da coloro che usufruiscono di servizi di assistenza e in parte da realtà scelte come campione rappresentativo della condizione reale. In accordo ai criteri del DSM-III, la maggioranza dei rispondenti sono stati classificati come aventi disturbi o legati all'abuso di alcool o di droga (il 71% degli intervistati). I risultati che si hanno dall'analisi della regressione logistica multivariata indicano che la durata del tempo in cui si è in una condizione di "senza tetto" è associata positivamente al rischio di un abuso di alcol o droga. Vengono trattate le implicazioni di queste scoperte e le raccomandazioni per i servizi di intervento.

Substanzmißbrauch bei jugendlichen Obdachlosen und Ausreißern

Zusammenfassung

In dieser Studie wurden systematische Methoden der Stichprobenbildung zur Rekrutierung eines Samples von 432 obdachlosen Jugendlichen benutzt, wobei sowohl an "Szene-Treffs" als auch in Hilfseinrichtungen rekrutiert wurde. Die Mehrheit der Befragten (71%) wurde nach einem von der Amerikanischen Psychiatrischen Gesellschaft entwickelten Set standardisierter diagnostischer Kriterien (DSM-III) als Alkoholabhängige und/oder Benutzer illegaler Drogen klassifiziert. Die Ergebnisse multi-variater logistischer Regressionsanalysen deuten darauf hin, daß zwischen der kumulierten Dauer der Obdachlosigkeit und dem Risiko, alkohol- und/oder drogenabhängig zu werden, eine positive Beziehung besteht. Die Implikationen dieser Ergebnisse und Empfehlungen für Interventionen von Hilfseinrichtungen werden diskutiert.

Drug- en alcoholgebruik onder weggelopen en dakloze jongeren

Samenvatting

Het onderzoek maakt gebruik van een steekproef van 432 thuisloze jongeren, die volgens systematische steekproefmethoden zijn verkregen vanuit zowel dienstverlenende instellingen als uit opvangcentra. Volgens DSM-III criteria kan de meerderheid (71%) van de respondenten worden getypeerd als 'heeft een alcoholprobleem en/of kent onwettig druggebruik'. De resultaten van multivariate logistische regressie geven aan dat de verblijfsduur als dakloze bijdraagt tot misbruik. Naast de implicaties van de resultaten worden ook de aanbevelingen met betrekking tot de activiteiten van de dienstverlenende instellingen besproken.

Наркомания среди сбежавших из дома подростков и бездомной молодежи.

Краткое содержание.

Настоящая работа использует методы систематического эксперимента на примере 432 человек из среды бездомной молодежи. Часть данных получена из различных учреждений, часть с мест сборищ молодежных компаний. Согласно критерию DSM- III, большинство опрошенных - 71% были определены как злоупотребляющие наркотиками. Результаты анализа многовариантной логистической регрессии показывают, что длительность жизни на улице напрямую связана с повышением риска нарушения общественного порядка. В статье также обсуждается значение этих данных и рекомендации по вмешательству различных служб.

離家出走及無家可歸青年的物質濫用失常

本研究用系統抽樣法從服務機構及自然出沒地點選出四百三十二個無家可歸青年作爲樣本。根據 DSM-III 的標準，大部份被訪者可被分類爲酒精及或違禁藥物濫用失常者(百分之七十一)。多元邏輯斯蹄迴歸分析結果顯示，累積的無家可歸時間與濫用失常的危險度有著正的關係。本文將討論這些結果對干預服務的啓示。

مقدمة

مشاكل تعاطي المخدرات بين الشبيبة الهاربة من البيت والمتشردين منهم

لقد استخدمت هذه الدراسة أسلوب العينات المنتظمة لاختيار عينة من ٤٣٢ متشرد شاب من أماكن تجمع طبيعية لهم ومن أماكن الخدمة مع بعضهم البعض. حسب طريقة DSM-III , فان معظم المجيبون تم تصنيفهم حسب مشكلة تعاطي الكحول و/ أوتعاطي المخدرات (٧١ بالمائة منهم). وأظهرت نتائج تحليل ارتدادي منطقي متعدد المتغيرات بان التراكم الطولي للتشرد يرتبط ارتباط إيجابي بخطر تعاطي المخدرات. وستساعد هذه النتائج والتوصيات في تطوير طرق العلاج من تعاطي المخدرات.

DRUG USE IN NEPAL: THE VIEW FROM THE STREET

Joel M. Jutkowitz, Hans Spielmann, Ulrich Koehler, Jagdish Lohani, and Anil Pande [*Substance Use Misuse*, 32(7&8), 987–1004 (1997)]

This study uses qualitative research techniques to examine heroin use in Nepal. It explores the life histories of 16 heroin users in Kathmandu, the country's capital, emphasizing those who are street children or who are otherwise displaced. The cases document that the initiation of use in Nepal is a complex process which includes: certain personality traits; an early history of culturally acceptable use of alcohol, tobacco, marijuana, or hashish; peer influence; and the specific social setting of users. Outside (i.e., foreign) influences are included in the mix, but never as a single determinant of drug use. Factors specific to the Nepali scene include the traditional association of forms of marijuana with certain religious contexts and the availability of heroin. An additional factor is the poverty of the urban setting. The approach in Nepal to dealing with drugs primarily involves a realization of the role played by the interaction between personality and social setting in the fullest meaning of that term.

Résumé

Cette étude recours à des techniques de recherche qualitative pour examiner la consommation d'héroïne au Népal. Elle explore les parcours de vic de 16 comsommateurs d'héroïne à Kathmandu, la capitale du pays, mellant particulièrement en évidence ceux qui sont des enfants des rues ou alors des déplaceés.

Les cas montrent que l'initation à la consommation au Népal est un processus complexe, lequel comprends: certains traits de caractère, une acceptation, depuis longtemps culturellement reconnue, de la consommation d'alcool, de taba, de marijuana ou de hashish, l'influence des pairs, et l'environnement social particulier des consommateurs. Les influences extòrieures (par exemple étrangèrcs) font partie de ce tout, mais jamais en tant que facteur unique influençant la consommation de drogue.

Les facteurs spécifiques à la scène népalaise comprennent l'association traditionnelle des différentes formes de marijuana à certains contextes religieux et la disponibilité de l'héroïne. Un facteur supplémentaire est la misère dans le paysage urbain.

L'approche, au Népal, du traitement des drogues requiert une prise de conscience du role joué avant tout par l'interraction entre la personnalité et l'environnement social, dans le vrai sens du terme.

Riassunto

Questo studio usa techniche di ricerca qualitative per esaminare l'uso di eroina in Nepal. Esplora le storie di vita di 16 persone che fanno uso di eroina a Kathmandu, capitale della nazione, dando particolare rilievo ai bambini di strada o a coloro che sono profughi. I casi mostrano che l'iniziazione all'uso di eroina in Nepal è un processo complesso, che include: alcune caratteristiche della personalità, una storia culturale di accettabilità precoce dell'uso di alcool, tabacco, marijuana o hashish, l'influenza dei coetanei, e la specifica posizione sociale di coloro che ne fanno use. Le influenze esterne (cioè straniere) sono incluse in tutto ció, ma non determinano mai singolarmente l'uso di droga. Fattori specifici della scena nepalese includono l'associazione tradizionale di uso di marijuana con alcuni contesti religiosi e con la disponibilità di eroina. Un fattore addizionale è la povertà della condizione urbana. L'approccio in Nepal che ha relazione con le droghe, include una realizzazione del ruolo svolto dall'interazione, soprattutto, tra la personalità e la situazione sociale nel senso più completo del termine.

Drogengebrauch in Nepal: Aus der Straßenperspektive

Zusammenfassung

Der Heroinkonsum in Nepal wird in dieser Studie mit qualitativen Techniken untersucht. Die Lebensverläufe von 16 Heroinabhängigen in der Hauptstadt Katmandu werden exploriert, wobei insbesondere Straßenkinder und andere Obdachlose betrachtet werden. Wie die Fälle zeigen, ist der Schritt in den Heroinkonsum in Nepal ein komplexer Prozeß, in dem folgende Faktoren eine Rolle spielen: bestimmte Persönlichkeitsmerkmale; frühe Erfahrungen mit kulturell akzeptiertem Gebrauch von Alkohol, Tabak, Marihuana oder Haschisch; Einfluß Gleichaltriger und die spezifische soziale Situation der Konsumenten. Ausländische Einflüsse spielen auch eine Rolle, sind aber nie die allein ausschlaggebenden Determinanten des Drogengebrauchs. Spezifische Faktoren der nepalesischen Szene sind u.a. die traditionelle Verknüpfung von Marihuana mit bestimmten religiösen Kontexten und die Verfügbarkeit von Heroin. Die Armut im städtischen Kontext stellt einen zusätzlicher Faktor dar. Der Ansatz für den Umgang mit Drogen in Nepal setzt eine Berücksichtigung der Rolle voraus, welche die Interaktion zwischen Persönlichkeit und sozialem Kontext im umfassendsten Sinne des Begriffs spielt.

Druggebruik in Nepal: het beeld vanaf de straat

Samenvatting

Deze studie maakt gebruik van kwalitatieve onderzoekstechnieken om heroïnegebruik in Nepal te onderzoeken. Het onderzoekt het levensverloop van 16 heroïnegebruikers in de hoofdstad Kathmandu., waarbij straatkinderen als aparte groep worden onderscheiden. Het blijkt dat de aanleiding van druggebruik in Nepal een complex proces is, dat onder andere wordt bepaald door bepaalde gedragskenmerken, de vanoudsher maatschappelijke acceptatie van gebruik van alcohol, tabak, marihuana of hashies, onderlinge beïnvloeding door familieleden en de specifieke sociale omgeving van gebruikers. Buitenlandse invloeden spelen weliswaar een rol, maar zijn niet doorslaggevend. Typische factoren voor Nepal betreffen de traditionele relatie tussen marihuana en religie, en de beschikbaarheid van heroïne. Ook is de armoede in de geürbaniseerde gebieden nog een factor. De drugsaanpak in Nepal vraagt echter bovenal aandacht voor de relatie tussen persoonskenmerken en de sociale structuur in de breedste zin van het woord.

Наркомания в Непале. Взгляд со стороны.

Краткое содержание

В настоящей работе, описывающей употребление героина в Непале, использованы количественные методы. В ней описывается 16 наркоманов из Катманду, столицы Непала. Особое внимание уделяется в работе уличным детям и перемещенным лицам.

Данные эксперимента показывают, что приобщение к наркотикам - сложный процесс, включающий целый ряд факторов: личные качества, употребление алкоголя с раннего возраста, курение табака, марихуаны, гашиша, влияние сверстников, особенности социального окружения. Среди специфичных для Непала факторов можно указать употребление наркотиков, связанное с исполнением некоторых религиозных обрядов, наличие героина в свободной продаже, а также крайнюю бедность горожан.
Подход к борьбе с наркоманией в Непале основан на выявлении отношений личности с социумом в самом широком смысле слова.

尼泊爾的藥物使用：街頭的看法

本研究用定質研究方法去了解尼泊爾的海洛英使用。它探討在首都加德滿都的十六個海洛英服用者的生命歷程，強調他們是街頭少年或是遭人排斥的人。這些個案顯示在尼泊爾，服用的開始是一個複雜的過程，它包括：某些個性特徵、有社會文化可接受的酒精、煙草、大麻或草使用的早出現的歷史、友輩影響，及服用者所處的特別社會環境。外面(即國外)的影響也包括在有關因素內，但永不是藥物服用的單一因素。特別與尼泊爾有關的因素包括各種大麻與某些宗教情景的傳統關連，以及海洛英有多容易取得。一個額外因素是都市的貧窮。尼泊爾處理藥物濫用的辦法涉及使性格及社會環境兩者得以眞正發揮後的互動所扮演的角色。

مقدمة

تعاطي المخدرات في نيبال, نظرة من الشارع

تستخدم هذه الدراسة أساليب البحث النوعي لفحص استخدام الهروين في نيبال. استكشفت هذه الدراسة تاريخ حياة ١٦ من متعاطي الهروين في كاتماندو (Katmandu), عاصمة البلاد, مع التركيز على من هم أطفال شوارع أومتشردين. تظهر معظم الحالات أن عملية البدء بالتعاطي في نيبال هي معقدة

جدا وتضم ما يلي: صفات شخصية معينة, تاريخ مبكر مقبول من ناحية ثقافية للكحول والتدخين والماريجوانا والحشيش وتأثير الأصحاب والوضع الاجتماعي لمتعاطي المخدرات بين المتعاطين, بالإضافة إلى التأثيرات الخارجية الأخرى وهذا لا يكون أبدا مؤثر وحيد على التعاطي. إن التأثيرات المرتبطة بشكل خاص بالوضع النيبالي تضم ربط استخدامات الماريجوانا ببعض التقاليد الدينية الخاصة, وتواجد الهروين. هناك سبب إضافي آخر هوالفقر في المناطق الريفية (urban). إن الأسلوب المستخدم في نيبال للتعامل مع المخدرات له ارتباط مباشر مع العلاقات الشخصية والاجتماعية بكامل معانيها.

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